HARVARD MEDICAL

Alumni Bulletin
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About the cover: Does our cover portrait look familiar? It should — it has been hanging in the Vanderbilt Hall Common Room for years, perhaps ever since that room was dedicated to Charles Herbert Best. Although the identity of the portrait's subject has not been positively confirmed, Mary Sunday believes that Best, one of the discoverers of insulin, is indeed the man in the painting. (Sunday's article, "Canada's Best," begins on page 10.)

With this issue the *Harvard Medical Alumni Bulletin* completes its 54th year, the tenth and final volume produced under the distinguished editorship of George S. Richardson '46, who has chosen to step down. J. Gordon Scannell '40 has agreed to become the new editor.

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The Dean reports

The day the Dean came to lunch the only thing anybody wanted to talk about was the Harvard Community Health Plan. This particular luncheon was sandwiched between the morning and afternoon sessions of the first day of this fall's Alumni Council meetings; after dessert and a bit of other business Dean Tosteson moved to the podium, only to discover that HCHP was (still) the issue of the day. However, before he was switched permanently onto that siding, the Dean had a few words to say about the rest of the railroad he's been working on. He announced the partition of the department of preventive and social medicine into a department of preventive medicine and clinical epidemiology and a department of social medicine and health policy; the appointments of Drs. Alexander Leaf and Leon Eisenberg, respectively, to head these new academic entities, and of Dr. David Hamburg, director of the University's Division of Health Policy Research and Education, to be vice-chairman of the latter; the selection of Dr. Howard Green, a cell biologist from MIT, to join the HMS faculty as professor and chairman of the department of physiology; and the endowment of the Shields Warren-Mallinckrodt Professorship of Clinical Research, in honor of the late Dr. Warren, professor of pathology, emeritus, at the New England Deaconess Hospital.

The councilors' questions — and the Dean's answers — about HCHP were not substantively different from those brought out in the June *Alumni Bulletin* or in this issue's "Letters." But the Dean's other news begs some further mention.

Departmental fission

The restructuring of the department of preventive and social medicine comes after four years of deliberation, and is intended to promote education and research in four areas: the application of advances in the biological and behavioral sciences to the prevention of human disease; the assessment of medical technology and medical practices for effective health care; the integration of the social sciences and humanities into medical research and practice; and the preparation of physicians for leadership roles in the formulation of health policies.

The department of preventive medicine and clinical epidemiology will be responsible for the first two of these goals. At the October 10 meeting of the Medical School faculty, when Dr. Leaf was introduced as chairman of the department and the new Ridley Watts Professor of Preventive Medicine (taking over that chair from Dr. David Rutstein, now emeritus), he spoke of plans to foster research and training in biostatistics, clinical epidemiology, occupational medicine, and toxicology; to enhance teaching in nutrition; to develop programs in ecogenetics (the identification of genetic bases for the varying susceptibilities of different population groups); and to assess the effects of particular changes in lifestyle on physiological function and general health. Leaf predicted that the scholarly activities of his department's faculty would lead them into closer collaborations with their colleagues at the Harvard School of Public Health.

Leaf comes to this assignment after fifteen years as chief of medical services at the Massachusetts General Hospital. He will be succeeded there by Dr. John T. Potts, Jr., chief of the MGH's endocrinology unit since 1968. Potts has also been nominated to become James Jackson Professor of Medicine, a position now held by Leaf. Dr. Dieter Koch-Weser, who has been chairman of the department of preventive and social medicine, is now Associate Dean for the Faculty of Medicine for International Medical Programs, and will be devoting more time to that expanding responsibility.

As chairman of the department of social medicine and health policy, Leon Eisenberg is Maude and Lillian Presley Professor of Social Medicine. Like most fledglings, his newborn charge has two, still-developing wings. One will support research and teaching in the social sciences (sociology, anthropology, economics, history, and law, among others) and the medical humanities (ethics and literature), bringing both to bear on problems of health, illness, and medical practices. According to Dean Tosteston, this structure should "permit us to develop more coherent educational offerings for all medical students, as well as for those substantial numbers who choose this field as a concentration area; to work with the Faculty of Arts and Sciences in developing courses for undergraduate premedical students; and to establish opportunities for combined M.D.-Ph.D. programs in several fields."

At the other end of this departmental wingspan is the HMS component of the pan-University Division of Health Policy Research and Education, chaired by David Hamburg. Because the government's policies on such issues as medical cost-containment, health insurance, the delivery of health care, and the allocation of resources for medical research, pediatric, and adolescent health all have so much to do with the ways medicine is practiced, the Dean believes "we clearly need a coherent body of knowledge in approaching these matters and in disseminating an appreciation of their importance to future generations of physicians, some of whom should seek careers in policy formulation."

Physiology chair to Howard Green

The search for a chairman of the department of physiology was exhaustive and international; yet, as Dean Tosteson was happy to report to the Alumni Council, it finally came to fruition last spring only a few miles from the Quadrangle. Howard Green's contributions to cell biology, over the course of two decades, have been seminal and diverse. He has achieved notable success in his studies of animal cell lines in culture and growth regulation, adenosine metabolism and its relation to a human im-

munodeficiency disease, cell hybridization and gene mapping on human chromosomes, and differentiation of cells in culture.

During the early 1960s Green was able to create families of established cell culture lines with special properties, thus helping to illuminate the process by which such cell lines are established, and their behavior with regard to growth and karyotypic alteration; their passage through a crisis, resulting in cell selection; and the roles of cell density and culture transfer interval in determining characteristics of the established lines. This research produced the 3T3 line, which has become the most commonly used cell line for studies of viral oncogenesis and growth control. Green and his fellow researchers also used these lines to conduct some of the first studies on how DNA viruses are transformed to oncogenicity.

In the late sixties, Green moved on to somatic cell hybridization; his work demonstrated that hybrids between human cells and mouse cells preferentially eliminate human chromosomes. The result of this research has been a method for the chromosomal mapping of human genes coding for observable properties — the method now most commonly used for making chromosome assignments of human genes. During his tenure at MIT, Green has focused his studies on the cell biology and biochemistry of cell differentiation. Working against the general expectation that cells in culture lose their ability to express differentiated function, he and his colleagues first showed that cultured fibroblasts could make collagen, a product of differentiation, and then later explored the effect of growth conditions and viral transformation on collagen-producing ability. Green's work on epidermal cells in culture may help scientists learn more about the behavior of human skin and could eventually lead to clinical applications in grafting for burn patients.

The breadth of Green's work may be explained by his own description of basic science research. "Much of it is accidental," he said. "When you do an experiment and you fail to get the answer you're looking for, but instead find something unexpected — which is often the case — the really important thing is whether the unexpected is worth pursuing. Of course, this sometimes involves a significant departure from the original intent of the work, but it may yield some very valuable information. That decision is the most important one you can make in research."

In his life before HMS, Green received an M.D. from the University of Toronto and an M.S. in Physiology from Northwestern University, and had postdoctoral training in biochemistry and immunology at the University of Chicago and the Walter Reed Institute of Research. He joined the faculty of the New York University School of Medicine in 1956, later became professor and chairman of that school's department of cell biology, and finally left for the position at MIT in 1970. Along the way he became a member of the American Academy of Arts and Sciences, and the National Academy of Sciences, and has been honored with the Taub International Memorial Award for Psoriasis Research, the Waksman Award in Microbiology, and the Rosenthiel Award in Basic Medical Research.

Deaconess professorship to honor Shields Warren

The New England Deaconess Hospital is an unquestionably apt place to establish the Shields Warren-Mallinckrodt Professorship of Clinical Research; Dr. Warren joined the hospital's staff in 1927, and continued to serve there until his death last July 1. He was pathologist in chief for thirty-six years, and was named professor of pathology in 1948. The chair formally recognizes "the many contributions of Shields Warren, M.D. to science, medicine, and medical education. Each recipient of the professorship shall have an interest in and a commitment to investigation in medicine."

The Deaconess and Harvard Medical School are presently seeking gifts to provide their half of the million dollar endowment; Mallinckrodt Inc. and The Edward Mallinckrodt Jr. Foundation have each already contributed a quarter of a million dollars to the fund.

Dr. Warren had maintained a close association with the Mallinckrodts during most of his career. He had been director of the company and president and director of the foundation, which was founded to support research in health and medicine. The Mallinckrodt Corporation had dedicated its own Pharmaceutical Research and Development Laboratories to Dr. Warren in 1978, citing Warren's "significant medical and scientific achievements and his many contributions to the corporation as director, consultant, and counselor."

When he announced the Warren-Mallinckrodt Professorship, Dean Tosteson referred to a history of Mallinckrodt support for research and education at Harvard. "Four professorships," he noted, "have previously been endowed by Mallinckrodt generosity. In honoring Shields Warren, the donors recognize a physician-scientist whose research on the health effects of radiation and subsequent recommendations for its safe use have had a major impact on health and environmental safety. His scholarly contribution as an investigator, his talent as a teacher, his warmth and humility as a person, and his ability to influence public policy in controlling the power of radiation, have found fitting and enduring recognition by the establishment of this professorship."

The Dean told the Alumni Council that Dr. Warren knew of the plans for the new chair, and a few months before his death had had the pleasure to acknowledge this final tribute from his associates.

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This year's model

It happens every year. Many apply, some are interviewed, few are admitted. Those who are, and who decide to come, arrive in late summer, are duly greeted and feted and then quickly put to work. They are told, among other things, that 1984 (if you are reminiscing, feel free to substitute the appropriate date) is sooner than they think.

For the numerologists among you, a statistic or two. There were 4048 applicants this year (35 fewer than last year, while the national figure rose from 35,939 in 1979 to 36,141 in 1980): 2822 men and 1226 women. In the applicant pool, 344 were black, 108 were Mexican American, 38 were Puerto Rican, and 21 were Native American. In descending order, New York, California, Massachusetts, and Pennsylvania sent the most applicants to HMS; Harvard, Yale, Columbia, MIT, and Stanford were the colleges with the highest numbers represented. 944 students were interviewed: 648 in Boston, 181 on Admission Committee "road trips," and 20 by alumni interviewers.

The matriculating class of 167 has 123 men and 44 women. 20 HMS I's are black, 6 are Mexican American, 2 are Puerto Rican, and 3 are Native American. There are 7 faculty and alumni offspring: 2 faculty, 3 alumni, and 2 who are both. New York, California, Massachusetts, and Pennsylvania also led the way in admissions; Harvard, Stanford, Yale, MIT, and Berkeley are the schools best represented in the Class of 1984 (which includes 40 members from Harvard/Radcliffe, chosen from the 256 who applied). There are more non-science majors in this group, some 17%, compared with last year's 9.1%. The youngest new doctor-to-be is 19, the oldest 36, and 25 in the class fall into the 25 to 36-year-old range.

Now, without further undue ado, we present the:

Class of 1984

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West Barnstable, Mass. (Tufts)

Alperin, Michael D.
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Champaign, Ill. (MIT)

Andrews, Nancy C.
Syracuse, NY (Yale)

Arnold, John H.
Barrington, RI (Harvard)

Arvidson, Eric B.
Westboro, Mass. (Bowdoin)

Back, Anthony L.
West Chester, Penn. (Stanford)

Bailey, Erroll J.
Jacksonville, Ala. (Xavier)

Bailin, Michael T.
Mt. Vernon, NY (MIT)

Ballock, Robert T.
Greenville, Penn. (Harvard)

Barksdale, Edward M., Jr.
Lynchburg, Va. (Yale)

Belgrave, Claude D., Jr.
Bronx, NY (Queens)

Berdick, Thomas E.
Philadelphia, Penn. (Drexel)

Berman, Jeffrey N.
Peabody, Mass. (Harvard)

Berry, Daniel J.
Corvallis, Oregon (Dartmouth)

Betcher, R. William
New York, NY (Johns Hopkins)

Billet, Amy L.
Barrington, RI (Yale)

Bronstein, Andrew D.
Littleton, Colo. (MIT)

Broussard, Delma L.
Moorestown, NJ (Harvard)

Burke, Redmond P.
Saratoga, Calif. (Stanford)

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Concord, Calif. (Berkeley)

Carreon, Jesus Roberto R.
Silver City, NM (New Mexico State)

Casey, Richard
Compton, Calif. (Occidental)

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Baltimore, Md. (Harvard)

Chang, Michael
East Brunswick, NJ (Harvard)

Cheung, Alan H. S.
Honolulu, Hawaii (Hawaii)

Choi, Paul M.
Bronx, NY (MIT)

Chung, Jay H.
Bethesda, Md. (MIT)

Cigarroa, Ricardo I. G.
Laredo, Texas (Princeton)

Cobb, Nathaniel
Denver, Colo. (Fort Lewis)

Colt, Cathy A.
Sharon, Penn. (Carlow College)

Cooper, Lawton S.
Brookline, Mass. (Harvard)

Copley, Shelley D.
Boulder, Colo. (Harvard)

Coulman, Cathleen L.
Novato, Calif. (Berkeley)

Crossland, Kathryn D.
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Denlinger, Steven L.
East Petersburg, Penn. (Goshen)

Devey, Kevin R.
Harrison, NY (SUNY, Stony Brook)

Doucette, Joseph W.
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Floyd, Jon W.
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Hundert, Edward M.
East Brunswick, NJ (Yale)

Iezzoni, Lisa I.
Ridgewood, NJ (Duke)

Ivashkiv, Lionel B.
New York, NY (Columbia)

Jayasuriya, Anula K.
Tortola, British Virgin Isles (Harvard)

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Jobson, George W. M.
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Johnson, Paula A.
Brooklyn, NY (Harvard)

Johnson, Robert P.
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Washington, DC (Harvard)

Jordan, John E.
White Plains, NY (Cornell)

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Chestnut Hill, Mass. (Harvard)

Kaplan, Robert A.
Rancho Palos Verdes, Calif. (Harvard)

Kavena, Cedric F.
Keams Canyon, Ariz. (Univ. of Ariz.)

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Kenney, Richard T.
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Trooper, Penn. (Berkeley)

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Longmeadow, Mass. (Cornell)

by Sheila B. Blume

THE ALCOHOLISM IN OUR PATIENTS

So your patient is an alcoholic. Now what are you going to do about it?

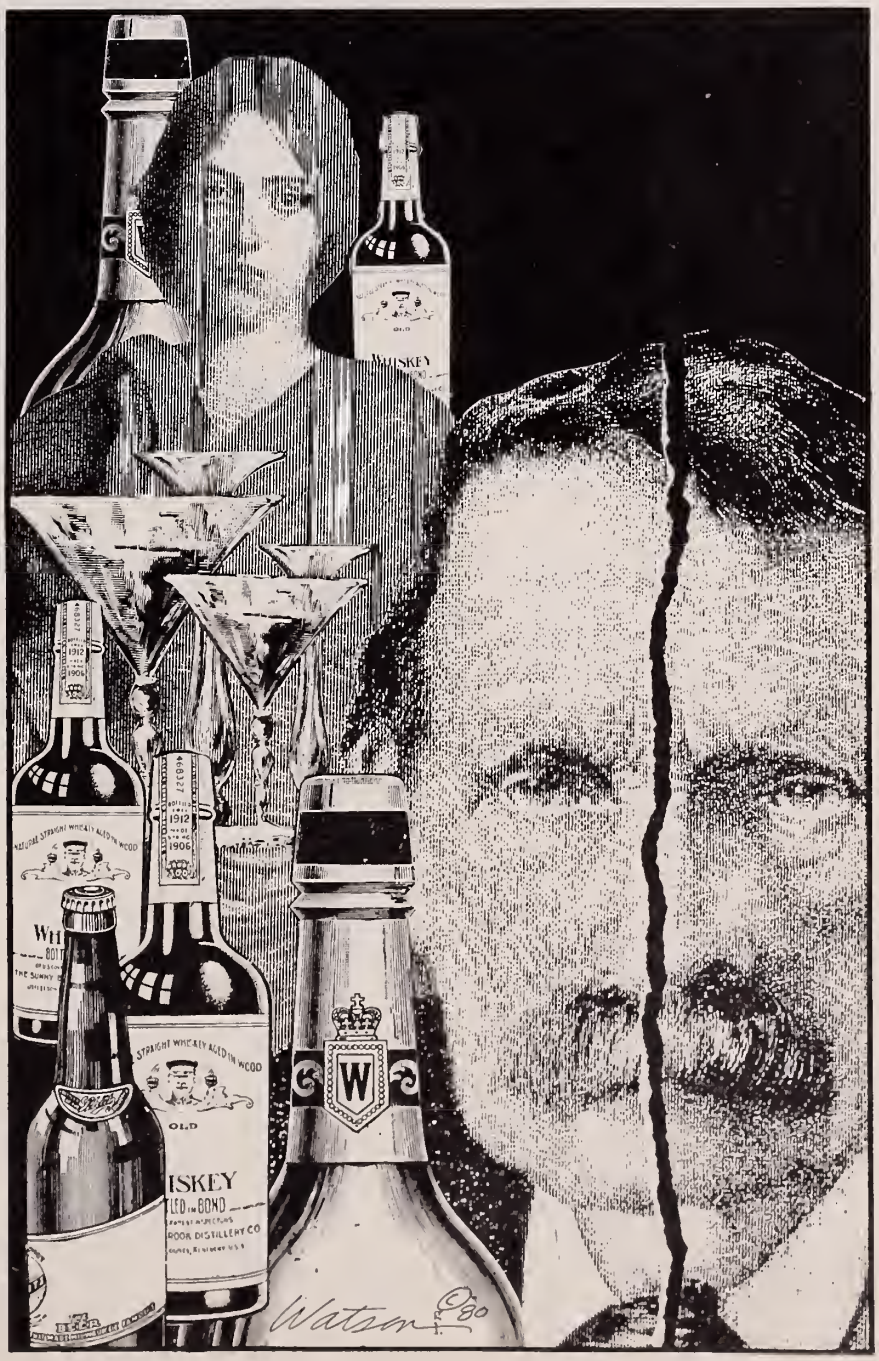
Sheila B. Blume '58 is director of the New York State Division of Alcoholism and Alcohol Abuse. She recently received the "Dr. Milton Helpern Distinguished Physician's Award for Outstanding Contribution to the Field of Alcoholism."

The patient was a seaman in his 40s with tattoos of flowers and anchors on his arms. He was referred to the neurology clinic because of a recent history of convulsions. I, as a third year Harvard medical student nearly twenty-five years ago, completed my first workup, examination, and diagnosis: alcohol withdrawal seizures, also known as "rum fits." I recall the praise from my instructor and the pride I felt as we discussed the findings with the patient. Rum fits. That was all. Neither I nor my mentor felt any responsibility for the treatment of the man's alcoholism. That, somehow, was *his* business.

Much of our medicine at HMS in those days was learned from alcoholics, of which Boston was said to have an abundant supply. Medical workups often began, "This 53 year old alcoholic . . ." (or sometimes "ethanolic," to be cute). We looked upon the alcoholism as a given attribute of the individual — like age, sex, or nationality. It was quite different from the term "diabetic," which implied medical responsibility for diagnosis, assessment, regulation, and management.

I occasionally think about that seaman I met so many years ago. He had cleaned up and dressed up for the appointment. He was frightened, as most of our patients are, and consequently more amenable at that moment to sympathetic intervention into the progress of his alcoholism than perhaps at any other time in his life. I missed that golden opportunity as I missed countless others in the men and women I treated when I was a student. When I think of him and the others it is with the hope that they somehow were able to find the help they so desperately needed — the help that I and my colleagues had failed to provide.

Today, almost twenty-five years later in spite of the greater availability and effectiveness of alcoholism treatment, there is evidence that the medical profession continues to miss these



opportunities for intervention.[1] I believe there are a number of factors that interact to sustain the status quo.

The disease concept: an uneasy acceptance

Although the idea that alcoholism is a disease (or illness, or syndrome) has been with us since Benjamin Rush in the late eighteenth century, and is subscribed to by most physicians, alcoholism is thought of differently than other diseases. Other illnesses "happen to people." Alcoholism is considered self-inflicted, a product of "lifestyle," and thereby it retains its societal moral stigma, even in the consulting room. This makes the physician uncomfortable in suspecting an alcohol problem in his middle or upper class functioning and paying patients, and even more uncomfortable in confronting the patient in whom the problem is obvious.

I find the "self-inflicted" argument quite curious. If a youngster slips and fractures his ankle on the basketball court, we do our utmost to provide the best possible care. We would hardly think of dismissing that problem as self-inflicted, even though nobody forced him to play basketball. Participation in sports is a socially approved activity and involves a known risk. We treat its casualties with care and compassion, and include them in health insurance coverage. Drinking alcohol is also a socially approved and strongly promoted activity in our culture, in spite of the fact that roughly one out of ten American drinkers experiences serious alcohol-related problems.[2] Alcoholism is one of the casualties of this particular approved behavior, and should be treated accordingly.

Although definitions of "alcoholism" have varied — so that both the World Health Organization's *International Classification of Diseases 9* and the American Psychiatric Association's *Diagnostic and Statistical Manual III* have chosen to use the term "alcohol dependence syndrome" — criteria for its diagnosis are widely available.[3] Recent research has compiled considerable evidence for a strong genetic predisposition to alcoholism, at least in men.[4,5] Other studies have cast doubt on early psychopathology as a necessary causal factor. Vaillant, for

example, in following a male cohort of physically and mentally healthy students of an ivy league college in the years 1940-1942, found that fourteen percent of the sample had developed a drinking problem by the age of fifty. Although unhappy childhood, personality instability in college, and adult evidence of personality disorder correlated with so-called "oral-dependent" traits in adulthood, they showed no correlation with alcohol problems. The many psychological difficulties in these problem drinkers were found to be a *consequence* rather than a *cause* of their alcoholism.[6] The incidence of alcohol problems did correlate with a positive family history of the disease.

What we now think of as alcoholism will probably turn out to be a group of "alcoholisms," related syndromes with different causes and natural histories. This fact should in no way deter the acceptance of the disease concept as applied for those who have lost voluntary control of their intake of alcohol and can be restored to health through treatment and rehabilitation.

Lack of emphasis in medical education

Joe Pursch, one of my colleagues who specializes in the treatment of alcoholism, regularly addresses medical audiences as "fellow members of the four-two-one club, who spent four years in medical school and received an average of two hours of instruction on the nation's number one health problem." It remains true, in most undergraduate programs, that a great deal of time is spent teaching the complications of alcoholism, and very little devoted to the recognition and treatment of the disease itself. Most students graduate without learning how to take a good alcohol history and without learning how to present the diagnosis effectively, to motivate, and to treat or refer an alcoholic patient. Psychiatrists still complete residency training without having engaged in therapy with an alcoholic patient, their experience having been limited to diagnosing alcoholics only for the purpose of screening them out. Internists, family physicians, and others in primary care face equally limited train-

ing experiences. Is it surprising, then, that many practicing physicians prefer not to treat alcoholics and that even those who are willing to deal with the disease fail to recognize alcoholism when they see it?

Many groups have been working to remedy this deplorable situation. Summer schools around the country, such as the Rutgers Summer School of Alcohol Studies, offer special courses for physicians. Training combined with direct patient care experience is provided to U.S. Navy physicians at the Long Beach, California Naval Hospital, and to civilian physicians by Roosevelt-St. Luke's Hospital in New York City, among others. The American Medical Society on Alcoholism, medical arm of the National Council on Alcoholism, sponsors and accredits continuing medical education courses in the field. Self-study materials are also available.[7]

At the undergraduate level, Operation Cork, an experimental program for alcohol-related teaching, was begun in 1977 at Dartmouth Medical School. The program has a strong evaluative component. Similar Cork programs are now being developed at the University of Colorado, Morehouse, Rush, University of Washington and Case Western Reserve medical schools.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) have jointly sponsored a grant program to support career teachers in alcohol and substance abuse since 1972. There are presently more than sixty such teachers in U.S. medical schools taking part in the program. Another current NIAAA initiative is the development of alcoholism components to be incorporated into thirty-nine family medicine teaching programs.

These efforts, while commendable and useful, are fighting an uphill battle against the negative attitudes passed on from generation to generation of medical students by their role models, the attendings and the house staff. A definitive solution to this problem of attitude continues to elude us.

Alcoholism in women: a special opportunity

From what little is known about alcoholism in women, we suspect that such women differ in many ways from their male counterparts.[8] They start drinking and begin their pattern of alcohol abuse later in life than men, yet appear for treatment at about the same age, presenting a more rapid or "telescoped" development of the disease. They are more likely to develop secondary dependence on sedatives, minor tranquilizers, or amphetamines (usually iatrogenic), and are more likely to have past or present depression and a history of suicide attempts. They drink considerably less than male alcoholics on the average — for example, 4.5 ounces of absolute alcohol per day for women entering treatment versus 8.2 ounces of absolute alcohol per day for men, in one study[9] — but get just as sick, and may even have a higher rate of cirrhosis.

One very important difference is the motivations cited for entering treatment. For men the most commonly mentioned are problems on the job or with the law. In women the most frequent are problems with health and family. The medical profession is thus in an ideal position for casefinding. Nearly all alcoholic women visit physicians frequently during their illness, but the presenting complaints seldom directly mention drinking.

The recent delineation of the fetal alcohol syndrome (FAS) and other alcohol-related birth defects has added increased urgency to the need to identify problem drinkers among women.[10] FAS is thought to be the third leading cause of mental retardation due to birth defects, exceeded only by Down's syndrome and spina bifida. Of these, FAS alone is preventable. Adequate prevention must involve the diagnosis and treatment of alcoholism in women of childbearing age, in addition to effective public information campaigns. Interruption of heavy drinking during the course of pregnancy leads to lower fetal risk. We have here another golden opportunity to prevent and relieve human suffering. Will we miss it?

This brings me back to the seaman and the medical student, and the role and responsibility of the physician vis-a-vis the alcoholism in our patients. Are we doing them justice? Can we do better? I find myself communicating one more call for self-examination of our attitudes, prejudices, and educational deficiencies. One more call for action. One more job to do. Well, nobody ever told us that being a physician would be easy. □

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by Mary E. Sunday

Mary Sunday came to Harvard Medical School from the University of Toronto. She is now doing basic immunology research and will receive an M.D.-Ph.D. in 1982. Her interests in medical history and research inspired the talk "Canada's Best," which was presented on December 5, 1979 to the Boylston Medical Society.

CANADA'S BEST

At the age of twenty-two, Charles Best shared in the discovery of a hormone that had already been given a name: insulin

Anvone who has ever walked into the Vanderbilt Hall Common Room has encountered the portraits of many great doctors hanging there. The official records that identify those medical giants have been misplaced in the Harvard Medical Archives in Countway Library; however, from comparisons with old photographs, I believe that the portrait opposite the entranceway, of a young man with his hands in his pockets, depicts Charles Best — one of the twentieth century's great pioneers of medical research and the subject of this article. The gilt inscription above the doorway unquestionably dedicates the room to Dr. Best. Last year I was in touch with Mrs. Best, his widow, in Toronto, and she shared with me her recollection of the day the room was dedicated:

"I remember very well pouring tea in the Charles Herbert Best Room. I believe it was when it was first named for my husband. I am sure that Dr. Joslin was there."[1]

Indeed, Dr. Elliott P. Joslin, the Boston clinician and founder of the world-famous Joslin Diabetes Clinic, was also active on the Harvard Alumni Committee, and it was through his intercession that Vanderbilt Hall was built in 1927 to provide comfortable quarters and a common meeting-ground for Harvard medical students, many of whom had, until then, been living in destitution.

Years before, Dr. Joslin had visited Hart House, the students' meeting building at the University of Toronto, and recorded that there he "saw a vision for the Vanderbilt Dormitory in Harvard,"[2] which explains why I, as a first-year student at Harvard Medical School who had come here from Toronto, observed so many remarkable similarities between the two buildings. Joslin dedicated the lounge to his researcher friend, "to inspire the students, because when Charley Best . . . just at the beginning of his medical career, joined in the discovery of insulin, ipso facto he changed the status of medical students in the world from that of students to that of investigators."[3]

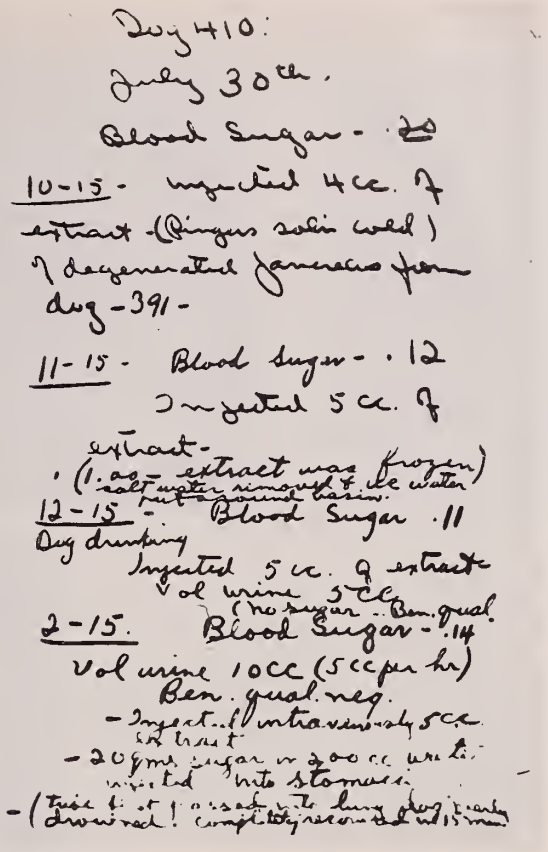
Diabetes mellitus has been a scourge of mankind since the beginning of recorded history. In Greek mythology it is written that Zeus condemned his son Tantalus to thirst and starvation in the presence of food and water. One can speculate that this referred to a life of insulin deprivation. An early possible document on diabetes is recorded by the Egyptians about 1500 BC. In the Papyrus Ebers, "a medicine to drive away the passing of too much urine" is described.[4] The Roman physician, Celsus, who lived from 30 BC to 38 AD, presented a good description of diabetes. And Aretaus of Cappadocia, who lived circa 100 AD described the disorder even more precisely, and coined the word "diabetes," which means "to flow through" or "to siphon off." He noted the characteristic features of the disease: unquenchable thirst, excessive urination, rapid loss of weight leading to emaciation, coma, and death.

In the sixth century AD, the East Indians described the urine of diabetics as "Madhumeha," or "the urine of honey." About 1000 AD the Arabian, Avicenna, referred to the sweetness of diabetic urine. Although the Swiss, Paracelsus (1493-1541) found four ounces of "salt" per liter of diabetic urine, it was the London physician, Thomas Willis (1621-1675), who rediscovered that diabetic urine tasted "wondrous sweet." This led another Englishman, Matthew Dobson, to note the sweet taste of serum in diabetes and to show chemically the presence of sugar in diabetic urine (1766). Finally William Cullen (1710-1790) coined the full term "diabetes mellitus" to describe the sickness. (Although medical students are called upon to do a lot of "scut work" for interns, happily, in this day and age, tasting urine is not included!)

In 1869 a young medical student, Paul Langerhans, from the University of Berlin, peering down his microscope at the pancreas, was the first to observe "cell heaps" not connected with the glands secreting the familiar digestive enzymes. However, *he* suggested no function for the cells which now bear his name.

In 1889 Minkowski, who was working in von Mering's laboratory in Germany, made a wager with his chief that a dog could not survive without its pancreas. Not only did he win his bet, but he also made the important discovery that excision of the pancreas led to rapidly fatal diabetes mellitus. This, taken together with Langerhans's observations of mysterious islands of pancreatic cells, led scientists to speculate that the islets secreted a hormone involved in the body's handling of sugar. One investigator, De Meyer, suggested that what was then only a hypothetical antidiabetic factor be called "insulin."

During the next thirty years experiments were designed by scientists all over the world in attempts to prove this controversial point. Most were doomed to failure, but a few came exceptionally close to isolating the hormone and even treating diabetes. One especially prominent re-



Banting and Best pose with their first insulin patient — one-tenth of their canine resources for what may have been one of the most cost-effective summer vacations in the history of biomedical research. Above, the first positive results.

searcher was Professor Paulesco of Rumania (who had *not* published prior to the beginning of Banting and Best's work in Toronto). His acute experiments were very successful.[5] The blood sugar of his dogs after pancreatectomy rose moderately high, and he was able to lower both blood sugar and ketone bodies with his pancreatic extracts. However, he did not observe the dogs for more than four days and did not attempt to purify his extracts — as Best later did with acid alcohol and fat solvents. Thus, his studies did not lead directly to the clinical use of insulin, although to this day the debate continues. (I am told that Dr. Ronald Arky, of Mount Auburn Hospital in Cambridge, is still receiving phone calls from Dr. Pavel, a physiologist in Bucharest, who continues to demand that credit be given to Paulesco for the discovery of insulin. It isn't possible to retroactively include Paulesco in the Nobel prize for the discovery of insulin — nonetheless, his name was remembered in 1971 during the celebration of the fiftieth anniversary of insulin.)

Still it was only Banting, an imaginative surgeon, and Best, an enthusiastic twenty-two-year-old graduate student, who succeeded in carrying the idea from conception through to the extraction of insulin and finally to the successful treatment of diabetes mellitus in people.

Who was this young Charley Best? He was born in West Pembroke, Maine, in 1899, in a house overlooking Passamaquoddy Bay, close to the borders of New Brunswick.[6] His forebears had come from England and Northern Ireland to the Annapolis Valley in Nova Scotia in 1749. He was a direct descendent of Major William Best, one of the founders of Halifax. His father started medical training at Dalhousie University and completed it in New York. He heard of a locum position in Pembroke and so the Bests moved there. They expected to stay only one or two years, but the senior Dr. Best became *the* physician in the Pembroke area for forty-six years. Young Charley was thus introduced early in life to the practical aspects of medicine and the rigors of a country practice. He often made rounds with his father in a horse and buggy and sometimes administered ether anaesthesia when his father operated in emergencies, often on a farmhouse kitchen table or a portable operating table. Best later reported, "The patients, I am glad to say, all survived."

When he was fifteen, Best's father's sister, a nurse at the Massachusetts General Hospital, developed severe diabetes. She was treated by Elliott Joslin, then a houseman, with the customary starvation regimen. She came to stay with the Bests at Pembroke and died in diabetic coma in 1918. This tragic episode made a deep impression on young Charles and sparked his interest in diabetes.

Charley lived in Pembroke until he finished high school, then in 1916 entered the University of Toronto. At first he was enrolled in a general arts program, but during World War I he enlisted in the Canadian Armed Forces and was shipped overseas on an old coastal steamer. Recording his memories of the harrowing trip, Best wrote: "Influenza broke out and there were many casualties. With no doctors

The principal players in this drama of medical discovery: at the top are the official Nobel laureates, Macleod (left) and Banting, flanking the University of Toronto's Medical Building, where the breakthrough was accomplished; to the right, Best and his wife, Margaret Mahon; and below them, their friend Elliott P. Joslin.

or nurses on board, those of us who remained well did what we could to help the ill. I attributed my own escape to sleeping on the top deck. Following this experience I was quite convinced that medical research would be my life's work."[7]

So, in 1919 he changed over to the honors course in physiology and biochemistry, a concentration designed to prepare students for medical research. He earned his B.A. in 1921, his M.A. in 1922, and finally his M.D. in 1925. His background in science, along with some experience in part-time research on diabetes with Professor Macleod in the department of physiology at the University of Toronto in 1920, gave him the special training in laboratory procedures essential for assaying the degree of metabolic disturbances of experimental diabetes, and of any putative, active pancreatic extract.

It was in October of 1920 that Best met Fred Banting, who was then working in London, Ontario. Banting was born in Alliston, Ontario, attended medical school in Toronto, and graduated in 1917. After a brilliant war record and postgraduate medical work in surgery, he began to practice in London, but was soon bored and discontented. He decided to pursue an idea that had come to him while preparing a lecture on diabetes. A paper published in 1920 by Moses Barron, "The Relation of the Islets of Langerhans to Diabetes with Special Reference to Cases of Pancreatic Lithasis," (*Surg., Gyn., and Ob.* v. 31 (5), Nov. 1920) triggered Banting's hypothesis. It had been observed that the acinar tissue, but not the islet, degenerated in patients whose major pancreatic ducts were blocked by stones. Banting reasoned that he might be able to minimize the destructive action of digestive enzymes on a putative antidiabetic hormone by using a similar ligation technique in experimental animals.

Since there was no authority in this field in London, Banting went to Toronto, where Professor Macleod, a great expert in experimental diabetes, was head of the department of physiology. He was very skeptical of Banting's intention to search for an antidiabetic hormone. Macleod himself had tried the experiment and failed, subsequently

forcing retraction from others who had published positive findings. In Macleod's words, Banting's quest would "go up in a pack of smoke." After elaborating on the abundance of negative findings, Macleod finally gave Banting permission to use a small laboratory in the deserted Medical Building for the summer. Realizing that Banting would need the help of a biochemist, Macleod asked for a volunteer from among his physiology students. Best, newly graduated, rushed forward. Macleod then went off to his native Scotland and left them to their project.

Time was critical, so the two men lived where they worked, during what turned out to be a typically hot and humid Toronto summer. In the small laboratory they had no research supplies, no pay, and only ten dogs for experimentation. Banting sold his car to buy supplies and food, which they cooked over a Bunsen burner. They took turns sleeping, rising at intervals to make tests and take measurements. They began with Banting doing the surgery and Best the biochemistry, but as time went on each learned some of the other's methods and the research soon became truly cooperative.

What were their techniques? First they ligated the pancreatic ducts and allowed the exocrine pancreas to atrophy. Later the remaining pancreas was excised and extracted with acid alcohol, and the product, first called "isletin," was injected into the dogs made diabetic by pancreatectomy. The accuracy of their blood sugar determinations was greatly improved by the use of a Duboscq Colourimeter. They were able to measure even minor changes in chemistry and thus establish dosage schedules to maintain the health of the animals.

Despite an initial six week delay due to technical difficulties, by July 30 they had their first positive results — not very startling, but encouraging. Over the next months they used the relatively crude pancreatic extracts to achieve convincing decreases of blood sugar, clearing of sugar and ketone bodies from the urine, and much improvement in the clinical condition of the dogs. One, Marjorie, lived for seventy days and showed dramatic improvement — she was the first dog in history to demonstrate the prolonged beneficial effect of daily injections of insulin. Later on, animals lived for ten to twelve years with daily injections.

When Professor Macleod returned from Scotland in September he was, as Best himself recalled, "incredulous," and insisted that they repeat the experiments over and over, more than seventy-five times! So it was not until November 14, 1921 that Banting and Best presented their findings for the first time, before the Physiological Journal Club at the University of Toronto.

In "The Best Biography," Dr. William Feasby reconstructs that historic scene in the library of the old medical building: old volumes lining the oak-panelled room, high windows overlooking the campus, the well dressed Professor Macleod speaking comfortably from his chair in his thick Scottish accent, introducing the more casually dressed researchers. Banting, by nature a very shy man, became forceful and vibrant as he spoke, "the light flashing on his gold-rimmed spectacles." Best, a tall, well built fellow, was glowing with enthusiasm as the data were presented. The audience, first amazed, was soon astonished. "Here," Dr. Feasby recalls, "in the quiet backwater of a provincial university, a great medical discovery had been made. The future of the research . . . seemed to be perfectly assured on that November afternoon as darkness fell and the lights came on around the campus."[8]

A month later, they encountered equal enthusiasm at a meeting of the American Physiological Society at Yale University, and again at the Toronto Academy of Medicine on February 7, 1922. Their now classical paper, "The Internal Secretion of the Pancreas,"[9] was published in the February, 1922 issue of the *Journal of Laboratory and Clinical Medicine*. In the five papers put out by the Banting and Best group in 1922, they established that their extract normalized the various diabetic metabolic deviations in depancreatized animals: lowering their blood sugar; curing thirst, excessive urination, dehydration, and acidosis; and, above all, prolonging their lives.

The team was besieged by scientists, patients, and their families, as well as by scientific journals and the press. However, the researchers' paramount concern was to test their extract on a human diabetic. They had already injected each other with large doses and encountered no adverse effects. The first human diabetic patient to be treated with the new extract was Leonard Thompson, a fourteen-year-old boy given his initial injection in the Toronto General Hospital on January 11, 1922. Almost at once he showed marked improvement and was soon out of danger. He lived for eleven years on continued insulin therapy, then died of bronchopneumonia following a motorcycle accident.

The clinical success was the fulfillment of their dreams and the beginning of a new era. Banting and Best informed Dr. Joslin of their discovery, and Dr. Joslin began the work that made him, and Boston, focal points for the treatment of diabetes. In this way a collaboration was set up between Toronto and Boston that continues to this day.

James Havens, the first insulin patient in the U.S., went on to become a celebrated artist. Dr. George Minot of Harvard Medical School, a severe diabetic, was one of Dr. Joslin's first patients to receive insulin. (After his recovery, Minot devoted himself to work on pernicious anemia and, with Drs. Murphy and Whipple, discovered the treatment for *that* disorder.) And the list goes on. King George V, H. G. Wells, Francisco Franco, Nikita Khrushchev, and Gamal Abdel Nasser, all owed their lives to insulin.

Yet Drs. Banting and Best never made a fortune out of their discovery. The patents were sold for one dollar to the University of Toronto on the condition that royalties never be charged for the manufacture of insulin.

The world fame caught both men by surprise and was much more pleasant than the shock they felt over the controversy and bitter quarrels that developed quickly when Professor Macleod began to take credit for their research. As a well known professor and head of the physiology department, Macleod had political power on his side. He also developed what may be viewed as a conspiracy with a scientist by the name of Collip. Professor Collip, a biochemist from the University of Alberta, was present at the first lecture on insulin on November 14, 1921, and at that time expressed interest in joining the group. Macleod agreed, and in January 1922 Collip became involved in the further purification of insulin. He was given the task of manufacturing the potent extracts being used at the Toronto General Hos-

pital for treating diabetic patients. At this time Best was preparing only the preliminary extracts from beef pancreas. But Macleod and Collip were collaborating closely, eating lunch together every day and keeping their new data in the insulin studies to themselves. Banting and Best, stationed in a separate building, were thus deliberately excluded from the clinical development of their discovery. They weren't even invited to be present when Leonard Thompson was given his first injection.[10]

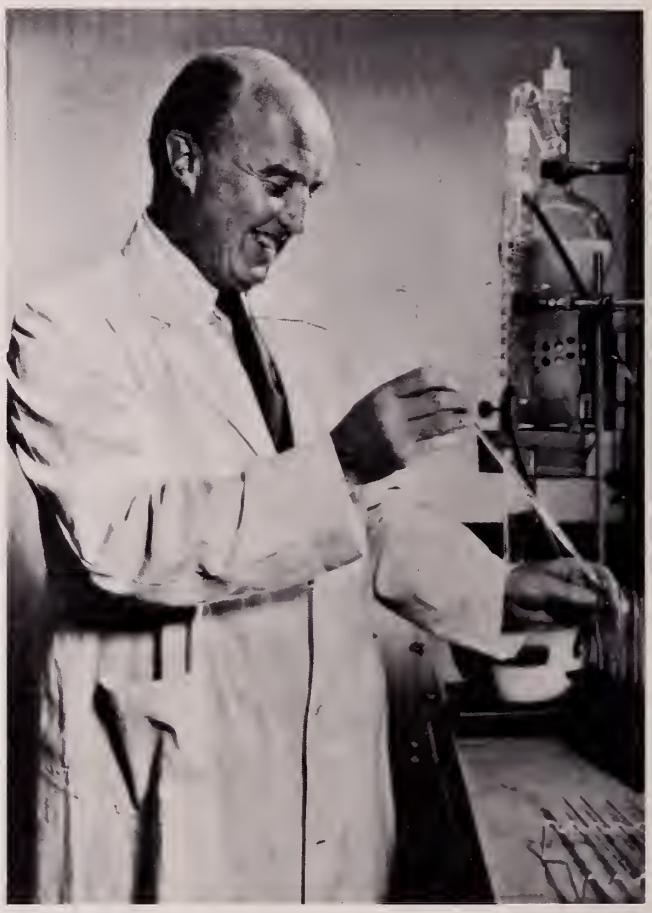
Best's loyalty to Banting throughout the controversy was unwavering. At one point Banting, who had stayed home for weeks in a very depressed state, was visited by Best. Banting explained that those in authority at the university were against him. He said he had no future in Toronto and would have to take a job elsewhere, perhaps with an oil company in South America. He told his friend: "Charley, you had better go back to the university; your friend Professor Macleod will look after you." Best replied: "Fred, if you go, I go."[11] This evidence of loyalty shook Banting into the realization that he still had many friends — and one in particular. He himself recorded that it was this statement, so simple and direct, that made him return to the laboratories to carry on. And carry on he did — as head of the Banting and Best Department of Medical Research, set up in 1923. He branched out into cancer research, and became a driving force in war research programs during World War II until his tragic death in an air crash in Newfoundland in 1941.

In any event, the disputes in 1922 led to Collip's withdrawal from the group.

In 1923, the Nobel prize was awarded for insulin. Although the recipients were Banting and Macleod, Banting felt very strongly that his assistant had been overlooked. It was, in fact, while Dr. Best was giving a special guest lecture on diabetes in Amphitheatre C at Harvard Medical School that he received a telegram from Banting. The message was read aloud before the audience: "I ascribe to Best equal share in discovery. Will share [Nobel prize] with him."[12] The audience went wild, and gave Best a standing ovation. Macleod, partly to spite the pair, shared his half with Collip. But he later admitted, "I did not win the Nobel prize for my discovery of insulin but for my discovery of Best."

Between 1922 and 1925, the group cooperated with the Eli Lilly company to perfect the methods of insulin production and purification on the scale necessary for its clinical use. The 1920s and 1930s were boom times for insulin research. In 1926, insulin was crystallized by Prof. J. J. Abel of Johns Hopkins University. In 1936, Dr. Hagedorn of Copenhagen found that when insulin was combined with a small amount of protamine, its action was slowed. And Drs. Scott and Fisher of Toronto discovered that the addition of zinc to protamine insulin gave daylong coverage to many diabetics.

Best became director of the insulin division of the Connaught Laboratories in 1923 and, as well, continued with his medical course. In 1924 he was married to Margaret Mahon, whom he'd met in 1919. Best described her as a "beautiful and highly intelligent girl . . . from St. Andrews, New Brunswick." (It is interesting to note that the Bests, on their honeymoon, stayed with Dr. and Mrs. Joslin at their farm in Oxford, Massachusetts. That close association between the two families has continued to this day.) Although a political science student at the University of Toronto, Margaret was closely involved in the biochemical aspects of Charley's work, and was "the only person [besides Banting and Best] who knew the progress of the insulin quest from day to day."[13] In fact, three pages of the original manuscript of the first paper are in her handwriting.



Portrait of Charles Best by Yousuf Karsh

In 1925, Best received his M.D. degree and won the Ellen Mickle Fellowship for graduating with the highest marks in his class. He then spent about two years working in the laboratories of Sir Henry Dale at the National Institute for Medical Research at Hampstead in the north of London. The research there on histamine led to Best's discovery of histaminase, and kindled his interest in heparin. When he returned to Toronto he initiated his studies of the purification of heparin and its potential for preventing experimental thrombosis; these efforts led to the use of heparin therapeutically.

Upon Best's return to Toronto, he was appointed chairman of the department of physiological hygiene (a position he relinquished at the end of World War II) and, with the retirement of Professor Macleod in 1929, became chairman of the department of physiology, where he remained until 1965 when he was named professor emeritus. With N. B. Taylor, Best wrote a widely used textbook on physiology, in addition to numerous scientific papers. Following Banting's death in 1941, Best took over as the director of the Banting and Best Department of Medical Re-

search. The opening of the Charles H. Best Institute in 1953 was "one of the most important events in [his] life."

In World War II, as director of medical research for the Canadian Navy, Best initiated a blood donor system by which more than two million units were dried and stored. The first five hundred donors were recruited from members of the staff and student body. Best recalled that "none seemed daunted by our rather primitive arrangements of having to climb on top of a lab bench, between the gas jets, to give a blood donation." The project was soon expanded to include the whole of Canada, with the complete cooperation of the government and the Canadian Red Cross.

Charley and Margaret Best had a host of friends around the world who loved and admired them for their kindness, ease of manner, and willingness to give help when needed. Over the years, Best was showered with honors. In 1971 he was made a Companion of the Order of Canada and a Commander of the Order of the British Empire by Queen Elizabeth II, and in 1972 he became the first Canadian ever to be named by the Pope to the Pontifical Academy of Sciences — the highest papal honor for scientists, all the more remarkable in that it was bestowed upon a lifelong Presbyterian.

Best was awarded honorary degrees from many universities around the world. He was president of the American Diabetes Association in 1948-49, honorary president thereafter, and held honorary positions in many other diabetes societies worldwide. Yet perhaps his greatest honor was simply to be stopped on the street — as he often was — by people who wanted to thank him personally for the benefit of his discovery.

Dr. Best suffered a serious heart attack in 1953, but it did not slow him down. Even though he retired officially in 1967, he continued to lecture widely on diabetes, and to act as consultant to the Hospital for Sick Children in Toronto, and, of course, to the Banting and Best Institute. He never failed to delight researchers of all ages, for new ideas always captivated him. During my own brief encounters with him while I was involved in research in immunology at Sick Children's Hospital, I was impressed with his brilliance and enthusiasm. He encouraged young scientists with his belief that the most essential quality for a medical researcher is "a driving motivation to add to the sum of human knowledge."

Home life always gave Best great pleasure. When he and Mrs. Best celebrated their golden wedding anniversary in 1974, it was with their two sons (one a Georgetown farmer, and formerly a member of Parliament; the other the president of Laurentian University in Sudbury) and seven grandchildren. Home, grandchildren and painting filled his later years, and his health was good until the end.

Quite suddenly in March 1978, his elder son, Alexander, forty-six years old, died of a heart attack. When Dr. Best heard of this, he collapsed. He was rushed to the Toronto General Hospital where, after two major operations to repair a ruptured aorta, he died six days later.

Diabetics everywhere reacted to his death with a deep sense of personal sorrow. It is estimated that during Best's lifetime he saved the lives of twenty-five million diabetics. His life serves to remind us that medicine is more than money, prescriptions, and waiting rooms; it is a broad, noble cause with a very proud tradition — something that tends to be forgotten in this new age of cynicism.

Best often said that he looked forward to the day when medical research would make insulin obsolete. There have already been many triumphs. Dr. Frederick Sanger of Cambridge, England received a Nobel prize for his determination of the chemical structure of insulin. Dr. Donald Steiner of Chicago has shown the conversion of pro-insulin to insulin within the cell. The physiology of insulin action is under intensive study. Transplantation of pancreatic islets is still at the experimental stage, but may be a feasible clinical alternative before long. Researchers in immunology have also been looking at specific HLA linkages in juvenile-onset diabetes, and at viral infections of pancreatic islets. Now it appears that diabetes isn't simply one disease, but a syndrome with multiple etiologies that span various age and ethnic groups. Classification is as important with diabetes as it is with cancer, so that treatment can be tailored to fit the individual. Recombinant DNA techniques are leading to the unlimited mass production of insulin, and someday genetic engineering may be able to correct the inherited defects that cause certain forms of the disorder. Although insulin has been able to adjust the blood sugar of diabetics and thereby prolong their lives, it cannot prevent the vascular complications that can lead to blindness, kidney failure, and sensory impairment. Current research is being directed towards these problems.

We certainly have come a long way since the days of ancient Rome. Yet the work of Banting and Best was truly *pioneering:* new paths have been opened. It is up to future investigators to continue. □

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WIT AND WHIMSY FOR BREAKFAST

A selection of choice morsels plucked from letters to The Times

"Have I gone batty, or is that really the first cuckoo?"

by J. Russell Elkinton

Emeritus professor of medicine, University of Pennsylvania, and editor emeritus, Annals of Internal Medicine, *J. Russell Elkinton '37 has retired with his wife to her native England.*

In a world saturated with bad news, what better medicine than the tonic of laughter? When my wife and I retired to her native England some years ago, we found a rich source of this precious elixir in "Letters to the Editor" in *The Times* (London's, of course). Naturally most of the letters published there deal with the serious issues of the day, are vastly informative, and, no doubt, let off much steam from the body politic. But it is not to those letters that I refer; rather it is to a steady stream of shorter, lighter ones that appear daily on the lower portion of the page. In these epistolary nuggets the wit and whimsy of the cultivated English mind are exhibited at their best — heartening flashes of light in a darkening world.

Is there a literate Englishman who does not cherish the hope of achieving a letter in *The Times*? Probably not, and one can only shed a tear over all the sparkling communications that must have failed to reach the light of *The Times* printed page. But those that make it apparently do so because they are highly individualistic or eccentric, witty, and above all, brief; the bull's eye to hit is the coveted lower right-hand corner. And the subjects? Well, they are myriad, and a topic once broached often triggers a veritable cascade of successive communications. *Times* letter writers (a motley crew of vicars, politicians, lords and ladies, bishops, and ordinary people like you and me) seem to be obsessed with subjects such as records ("Is this a record?"), numbers, words, names, gardens, wildlife, pets, social customs, and other matters trivial or significant. Let me share a few samples of this rich ore that we have mined from *The Times* over the past six years.

Is this a *record?* The traditional letter in this category in the past has usually been entitled "The first cuckoo" and has been used to signal the earliest date of that seasonal event. * In our collection it appears under "Their first cuckoo?":

> *Sir, I heard today the first cuckoo of this year. Is this a record for Outer Mongolia?*
> *Yours faithfully,*
> *David Mallon.*
> *Ulan Bator, Mongolia, June 4.*

Does this show to what lengths (or distances) *Times* letter writers will go to achieve publication? A close runner-up to the cuckoo is the swallow; two letters within five days of each other report the dates of the first swallow sightings — one for each of six years, the other for no less than twenty-five years. But the yearning for a record goes far beyond such ornithological data. Under the title "Eternal brightness," five correspondents vie to record the electric light bulb in longest continuous use (a tie between two carbon filament bulbs, both dating from the nineteenth century and presently rounding out one hundred years of use). "Is this a rekord?" asks Graham Green as he counts the thirty-seven misprints (due to the current industrial disputes) on page 4 of one copy of *The Times* and notes that "two defendants aged 3 and 0 were committed for trial at the Central Criminal Court." And read the following on "Losing luggage," from Derek Mayhew:

> *Sir, British Airways flight BA 329 left the Arabian Gulf on Tuesday, September 6 with just one passenger who had checked in just one piece of luggage.*
>
> *Is it some sort of record that the luggage failed to arrive with the passenger at Heathrow?*

Which communication is supplemented the next day by L. M. Wise:

> *Sir, Your correspondent's letter . . . reminds me of a graffito on a British Airways poster. It read, "Breakfast in London, lunch in New York." Underneath someone had chalked, "Luggage in Bermuda."*

As a final item on records comes "On the shelf" from David Holbrook:

> *Sir, In the last week I have had six books rejected by publishers. Is this a record?*

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* *This title, "The First Cuckoo," has been used as the main title of a recently published book containing "a selection of the most witty amusing and memorable letters to* The Times *1900-1975," chosen and introduced by Kenneth Gregory, Times Books, Allen & Unwin, London, 1976, 350 pages. Philip Howard,* Times *columnist, in his review in the paper (May 7, 1976) gives a professional and delightful analysis of the English world that reads and writes letters to* The Times.

This plea of pathos, if not of braggadocio, evokes the following response two days later from Paul Bonner:

Sir, readers of David Holbrook's letter . . . might reasonably feel that one rejection by a publisher may be accounted as literary misfortune. Two rejections in a week smacks of carelessness. Three might conceivably be seen as prejudice by publishers against the author. Four must surely begin to look like intellectual bankruptcy. Five is certainly a pointer towards the need for discreet retirement from the literary scene. Six rejections obviously represent an attempt to join that other world of letters – those written to The Times.

Who can deny that competition is the spirit of the times?

Numbers, as well as records, seem to have a fascination for letter writers to *The Times*. For instance, in a letter published under the title "The 7-7-77 club" and published July 7, 1977, the writer states that on that date his aunt would be 77 and he wondered how many other people could join her club. One respondent calculates that about 847 persons were born in the U.K. on July 7, 1900 and that at that moment about twenty of them probably were writing to *The Times* in response to the above letter. But one of the most intriguing samples of "Notable figures" is presented by Claud Dickens:

Sir, it is not only dates that make nice patterns of numbers. Some years ago I was bringing a Destroyer home from the Far East and was required to report my position twice a day.

One evening I saw that we would be passing close to where the Greenwich Meridian cuts the Equator and so arranged to arrive there dead on midnight. Once there I altered course to due North and stopped engines so my position signal would read:

At 0000 my position Latitude 00°00'E. Course 000°. Speed 0.

I considered saying I was Nowhere but thought (probably correctly) that their Lordships would not be amused.

Would a naval officer in any other but the Royal Navy think to execute such a delightfully original maneuver in numerology and then report it to readers of *The Times?* Is *this* a record?

However numerate or innumerate the English mind, *gardens* and *wildlife* are close to the English heart. For instance, "Christmas blooms":

Sir, on Christmas Day there were in full bloom in this garden polyanthus, campanula, pansy, scabious, rose, snowdrop, arabis, tobacco plant, love-in-the-mist, and, of course, hellebore and jasmine.

No doubt some one can cap this list, but I cannot recall ever before such a display at Christmas time.

Yours faithfully,
C. M. Barlow.
Winchester, December 27

They do. In the subsequent fifteen letters, the list reaches a total of seventy-two species of flowers in the Cheshire garden of astronomer Sir Bernard Lovell and seventy-seven in the Oxford garden of Mr. and Mrs. Fitter. However, the wind in the sails of this horticultural cornucopia (sic) begins to be spilled by Prof. Kenneth Mellanby's list of the Christmas weeds in his garden, and a final letter from Stanley C. Brown brings the voyage to an abrupt halt:

Sir, My garden is situated in a pleasantly quiet byroad. In recent weeks it has presented us with a truly remarkable display of toffee papers, chocolate wrappings, cigarette packets, crumpled potato crisp bags, cardboard fish-and-chip containers, numerous empty tins, odd newspaper sheets, and one hybrid interloper which, from a prudent distance, looked like a rejected haggis.

With us, however, these are not freak seasonal flowerings. We get them the whole blooming year round.

What astonishing reading these horticultural accounts from the mild winter of 1974-75 made in the savage winter of 1978-79! Now let us turn to summertime and another favorite subject: butterflies. Several letters report sightings of a rare visiting butterfly, the "Camberwell Beauty," necessarily a migrant from Europe or North America, insofar as the original British species has long since ceased to breed. One letter particularly caught my eye:

Sir, . . . In 1912 my father, on leave from the Navy, visited his brother-in-law, Sir Squire Sprigge, M.D., editor of the Lancet, in his offices above the Strand in London. They saw a Camberwell Beauty on a fruit barrow in the street below, ran down and caught it in a top hat.

Yours truly,
Elizabeth M. Scott.
Newbury, Berkshire.

Here indeed is an item, however minor, to be cherished in the history of medical editing!

Beyond flowers and butterflies, letters in the sphere of nature seem almost endless and include: "Weasels in line ahead" (six writers confirm that these small animals do indeed travel in single file); "The courteous gull" (ten correspondents speculate on why a gull sitting atop a flag pole invariably makes way for another gull wishing to alight); "Tottenham herons" (nine commentaries on how to preserve from such predators goldfish in the garden pools of that particular London

Christmas cheer, or cold comfort?

Witness the compleat medical editor . . .

locality); "Ladybirds galore," "Lobster quadrille," and so forth, even on to "The Loch Ness Monster."

No subject arouses *The Times* letter writers more than that of *pets*, and this usually means dogs versus cats. Bernard Levin, *enfant terrible* of the columnists in *The Times*, wrote a feature article entitled "Beware of the dog, the beast may be carrying a gun" in which, with wit and a great many words, he exalted the cat over the dog. The effect on readers of the paper was electric! In the twenty-seven *published* letters that immediately followed, dog lovers set out vehemently to put him down and cat lovers strove fervently to uphold his brief. Herewith a few excerpts to indicate the hilarious character of this prolonged exchange. Max Hastings writes:

Sir, While Bernard Levin has been plotting to shoot my dog, his may well be one of the cats at which I have been hurling broken china and half bricks all these years as they defecate in my garden . . . howl horribly on my wall in the dark watches of the night. . . .

Cats have no love for any man . . . They have a particular attraction for a certain species of urban man who likes animals only if they enter his sitting room without dirtying his antimacassars.

Now dogs on the other hand . . . There is something wholly delightful about muddy paws on the carpet . . . Dogs are modest while cats radiate the same air of superiority as seaside landladies who read The Tatler.

As for the spaniel that bit Mr. Levin, one can hardly fault its impeccable instincts.

Sir, of course the cleverest dog is more stupid than the least clever cat. Mr. Levin ought to have strengthened his argument by mentioning guide cats for the blind, guard cats, sheep cats, police cats . . . even cat teams in the Arctic. . . . (David McGill).

Sir, Mr. McGill deceives nobody. I can see him in my mind's eye grinning like a Cheshire dog waiting to see which way the dog jumps before he lets the dog out of the bag . . . he would be well advised to let sleeping cats lie.

Sir, Is there still *no undercat for readers to champion?*

"After you, Alphonse."

And on and on and on . . .

Social customs and situations regularly surface on *The Times* letter page. For example, under "Smiling at strangers," Mrs. John Miller writes:

Sir, when I was young and thin and smiled at strangers, they used to look at me as if I was – in the parlance of those days – no better than I ought to be.

Now, when I am old and stout and smile at strangers, they look at me as if I was slightly dotty.

Forty years is perhaps a little long to go on making the same mistake; can anyone tell me how to smile at strangers without being misunderstood?

Sir, Has Mrs. Miller tried a yashmak? It enhances mystery yet inhibits reaction . . .

Sir, To be smiled at by a stranger can be quite unnerving if one is over twenty. Should you know them? Do they know something that you do not? Are you about to tread on a banana skin? Oh, how untrustful one has become since one was young and thin and smiled at strangers . . . For reassurance the kindly gesture should be backed up by words — what a lovely child-dog-hat-briefcase. . . .

"The spread of kissing" comes in for light comment, first from Jane Gardam in Wimbledon:

Sir, has anyone noticed the recent extraordinary increase in middle-class kissing? . . . I thought at first I must suddenly have become loveable. Then I thought it must be the Jubilee . . . One isn't even safe in church.

To which author Geoffrey Trease responds:

Sir, . . . (It) is not so much a new phenomenon as a return to the warm-hearted tradition of Merrie England . . . Erasmus wrote to a friend in praise of English women: "They have one custom which cannot be too much admired. They kiss you when you arrive. They kiss you when you go away and they kiss you when you return." . . . Perhaps what your correspondent has remarked in Wimbledon is just part of the drive to attract more tourists from overseas.

And, as often, a last word from Wales:

Sir, The English may be returning to the warm-hearted traditions of Merrie England . . . We Welsh never abandoned ours.

In addition to the social niceties of smiling and kissing, more mundane problems are explored. Under "Apron or bib," the genteel use of the table napkin on the lap is ridiculed in relation to the practical use of tucking it under the chin. And the "Porridge while you walk" correspondence comprises fifteen letters of explanation of this curious custom from north of the border. Apparently, if the Scot be not at least standing while eating his porridge, he is less "ready to start off for the wars, or shooting or fishing next moment," or, perhaps, is laid open to a stab in the back. Also noted was an interesting variation in the custom: "Certain lairds may be observed walking about with their cornflakes."

But the letters regarding "An awkward shortage" surely must strike a responsive chord in those of us males who have reached "the age of the prostate":

Sir, I shall be grateful if you will allow me to draw public attention to the hardship that is increasingly experienced by septuagenarian men when they are away from home . . . I refer to the disappearance of the chamber pot as an article of bedroom, or rather of guest room furniture . . . We do not like to disturb our hosts by wandering about dark passages in quest of light switches and uncertain doors and at last by the noise of flushing.

We plead for the restoration of the traditional chamber pot to its rightful place under the bed or in a bedside cabinet. It is true that most of them now seem to have found their way into antique shops and thence to the United States. But various sizes in plastic are obtainable and, for my part, I am ready to settle for one of those as a substitute for an elegant

"My dear woman . . . I'm a married man!"

piece of china. Yours faithfully,
Dr. Alec Vidler,
Friars of the Sack,
Rye, Sussex.

This plea from the heart (by an eminent theologian) evokes a series of replies that include: advice to the Doctor to take in his suitcase his own plastic pot (with cover), the report of one pot in its proper place but upside down with a sign on top from the hostess OUT OF ORDER, the sighting of "the article prominently displayed on the luggage rack of a car speeding down the Champs-Elysées — a Vidler on the roof," and the comment from a New Yorker that Americans could hardly be blamed for the shortage in England as she had never seen a pot by a bed anywhere in the U.S., and that they must all be in museums. But this light exchange is capped by Bishop Kenneth Healey in a final letter:

Sir, It was in 1942, I think, that I enjoyed the relief of a long weekend at St. Deiniol's Library, Hawarden: the peaceful setting, the excellent company . . . Late to my room and writing home to say how wonderful it all was . . . And then, in that dark, strange, silent, darkened, seemingly vast building, I discovered the awkward shortage . . .

And who, think you, was the learned and kindly warden of that famous establishment? Yes: Dr. Alec Vidler. "He didna' ken, he didna' ken,' I take it; "but he kens th' noo!"

My own sympathies are still with poor Dr. Vidler.

Names — place, Christian, and nick — are good for many a letter. "Is there really such a place as Piddletrenthide?" evokes a torrent of astonishing place names that, alas, must go unrecorded here (my own favorite — and unpublished — offerings were Long Itchington and Upper and Lower Underly). The ten most common Christian names for newborn babies of each sex, as recorded in *The Times*, are reported faithfully each year by the same correspondent. And several letters on "Army nicknames" reveal labels for British generals that simply defy belief ("Squeaker," "Bubbles," and "Twinkletoes," to indicate a few of the more improbable).

Miscellaneous subjects are many and include, of course, such favorite English activities as cricket and pointing out deficiencies in the railways and the Post Office system; for example, "Slow post":

Sir, A letter was delivered this week . . . in a scarred and perforated envelope. In explanation, a Post Office official had added the legend "Found adhering to a snail."

Sir, A slightly battered envelope seems a small price to pay for what must be teething troubles in this totally new concept of reliable rapidity.

Among other subjects we must not fail to note the great "Greek trireme" controversy. Could the ancient Greeks have driven a trireme, a vessel presumably with three banks of oars, across the Aegean for one hundred miles from Ephesus to Delos, or for 140 miles from Byzantium to Heracleia, at a speed of twelve knots, with or without the aid of sails, as claimed by Thucydides and Xenophon? The epistolary fray is entered by sailors, archeologists, classical scholars, naval architects, historians, oarsmen, engineers, a computer expert, and a peer of the realm — all navigating across seas of ancient writings, modern calculations — such as horsepower per oarsman per waterline length per displaced ton — and other nautical and scholarly lore. Two months and thirty letters later the persevering reader knows only that C. P. Snow's two cultures do indeed exist. And in passing, John Masefield's "Quinquireme of Nineveh" is sunk without a trace!

In conclusion, I will illustrate my theme that letters to *The Times* are sparks of light in a darkening world, by quoting two more miscellaneous entries. Under "Approaching doom," Mr. T. P. Goldingham writes:

Sir, On page one today you report "One dead, nine ill from wasp stings"; on page three we read of a swarm of locusts 200 miles across; on page five, a boa constrictor strangles a man; while on page fifteen, a deadly tick spreads inexorably across Eastern Europe.

How much longer have we got?

Relax, says Flora Jacobs (on another matter), by "Writing to *The Times*":

Sir, There is an alternative other than suicide and actually posting a letter to The Times. *Write the letter but don't send it. That not only helps get it off your chest, but saves postage both ways.*

Better yet, read the letters that *are* published. □

Addendum: On November 13, 1979 *The Times* resumed publication, which had been suspended for 11½ months. During this "timeless" interval one spoof issue appeared entitled *Not (Yet) The Times;* it included the following letter from C. Nightingale:

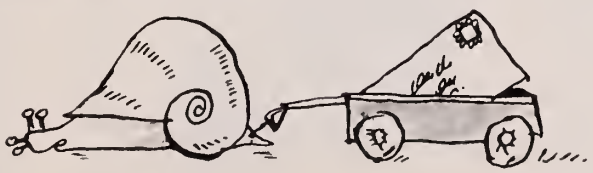
Sir, The first cuckoo was heard in Britain in 1979 without the date being recorded in The Times.

Is this a record?

The first new issue of the genuine publication lived up to its tradition of ornithological observation; in the coveted lower righthand corner of the letter page appeared this note from D. J. Connally:

Sir, Last Monday I believe I heard the sound of the first phoenix of the year. Who said it was extinct?

Welcome back.



Make way for the Escargot Express.

PRIDE, PREJUDICE, AND POLITICS

In the winter of 1850-1851, Oliver Wendell Holmes was willing to let Martin Robison Delany, the "Father of Black Nationalism," into Harvard Medical School. But in the fracas that followed, Holmes was not willing to let the black man stay.

Martin Robison Delany

by Philip Cash

Philip Cash, Ph.D., is professor of history at Emmanuel College.

In social terms, the academic year 1850-1851 was one of the most controversial in the Harvard Medical School's two centuries of existence. In that year one woman and three blacks, including Martin Robison Delany, "The Father of Black Nationalism" and great rival of Frederick Douglass for the leadership of the black community during the critical era of abolition, civil strife, and partial emancipation (1840-1880), applied for admission to the school. The woman was persuaded to withdraw her application while the blacks were allowed to attend for one semester and then dismissed. While from the perspective of another century and another era it is easy to condemn these actions in a self-righteous manner, it is difficult, but far more important, to understand them in their historical context.

In order to attain this historical perspective one has to have some understanding of the Boston of 1850. At that time the "hub of the universe" and "Athens of America" was growing, prosperous, and progressive. However, with this progress and prosperity came social conflict, economic dislocation, and deep anxiety. Widespread opportunity coupled with a laissez-faire social and economic system not only meant growth and mobility, but also waste, exploitation, and corruption. Furthermore, to sustain this growth, Boston, long noted for its stability and homogeneity, was forced to adjust to two new and unsettling forces: manufacturing and the Irish. This combination changed Boston from an urban community unusual in America for its social and cultural consensus to one that was uniquely polarized between WASP and Hibernian. Also, at this time antebellum reform was boiling up in New England, fueled by the ideological fires of Transcendentalism, Unitarianism, Universalism, and Swedenborgianism. These variegated and generally desirable, yet bitterly devisive, reforms, were then further complicated by abolitionism, temperance, and black and women's rights. Of these, abolitionism was the most explosive, and Boston was on the verge of civil conflict over attempts to enforce the newly enacted Fugitive Slave Act.

As a major Boston institution, Harvard Medical School could hardly escape the force of this turmoil. What is more, the school was still traumatized by a recent scandal of its own. This was the highly controversial conviction of John White Webster, professor of chemistry at the medical school, for the murder of Dr. George Parkman, a prominent, if not universally beloved, Brahmin, who had been a major benefactor of Harvard. Most seriously affected was Oliver Wendell Holmes, dean of the medical faculty and Parkman Professor of Anatomy, who had played an important role at the trial. Webster had been sentenced on April 1 and hung on August 30, 1850.

Clearly, Harvard Medical School in the fall of 1850 was not in a mood for any further excitement or conflict. However, before examining the challenge offered by the application of a woman and three blacks, it might be wise to review the admission requirements and the composition of the medical faculty at this time. The criteria for acceptance were basically the same as when the school had opened in

1782; three years training with a regular physician, evidence of good moral character, and a college degree (which only a small minority held) or a demonstration of a knowledge of Latin, mathematics, and basic science deemed satisfactory by the medical faculty. Unstated, of course, but traditionally assumed, was that acceptable candidates would also be white and male. Now these assumptions were being tested at Harvard as at a number of other medical schools.

The medical faculty in 1850 consisted of: Oliver Wendell Holmes, professor of anatomy and dean of the medical faculty; Walter Channing, professor of midwifery and medical jurisprudence; Jacob Bigelow, professor of materia medica and lecturer on clinical medicine; his son, Henry J. Bigelow, professor of surgery and clinical surgery; John B. S. Jackson, professor of pathological anatomy; John Ware, professor of the theory and practice of physic, and E. N. Horsford, newly appointed professor of chemistry — in place of Webster — and later dean of the Lawrence Scientific School. This was a medical faculty the equal of any in America at the time. These men were true Brahmins, steeped in tradition and used to success, status, and prestige. Yet, despite their considerable accomplishments and strong personalities, there is little doubt that the affable, adroit, and multi-talented Holmes, then at the height of his influence in Boston, was the dominant force in the school.

During the winter semester of 1850-1851 a number of events rocked the medical school. On October 22, a Mr. Charles Brooks sent a letter to the Harvard Medical faculty asking that one Daniel Laing, Jr., "a young man of colour," be admitted gratuitously to the winter course of lectures to prepare himself for the practice of medicine in the newly independent African state of Liberia. On November 1, the Massachusetts Colonization Society petitioned to have both Laing and Isaac H. Snowden, another black, admitted to the winter semester with the acknowledgment that they would subsequently emigrate to Liberia. Under the Society's direction, Laing and Snowden had been studying with Dr. Horace Clarke, a surgeon on the staff of the Massachusetts General Hospital. On November 4, with Horsford absent, the faculty voted four (Channing, Holmes, Jackson, and Ware) to two (the Bigelows) to accept Laing gratuitously and four to one, with only Bigelow, Jr., dissenting, to accept Snowden, whose fees would be assumed by the Colonization Society.

Laing and Snowden were native Bostonians and attractive and able young men. Both had been independent printers who despaired of getting ahead in a land of white opportunity. When they went to the Colonization Society to seek aid in getting to Liberia, the Society suggested that that country had too many printers and not enough doctors; it urged them to study medicine under the Society's auspices. Both men readily agreed to do so.

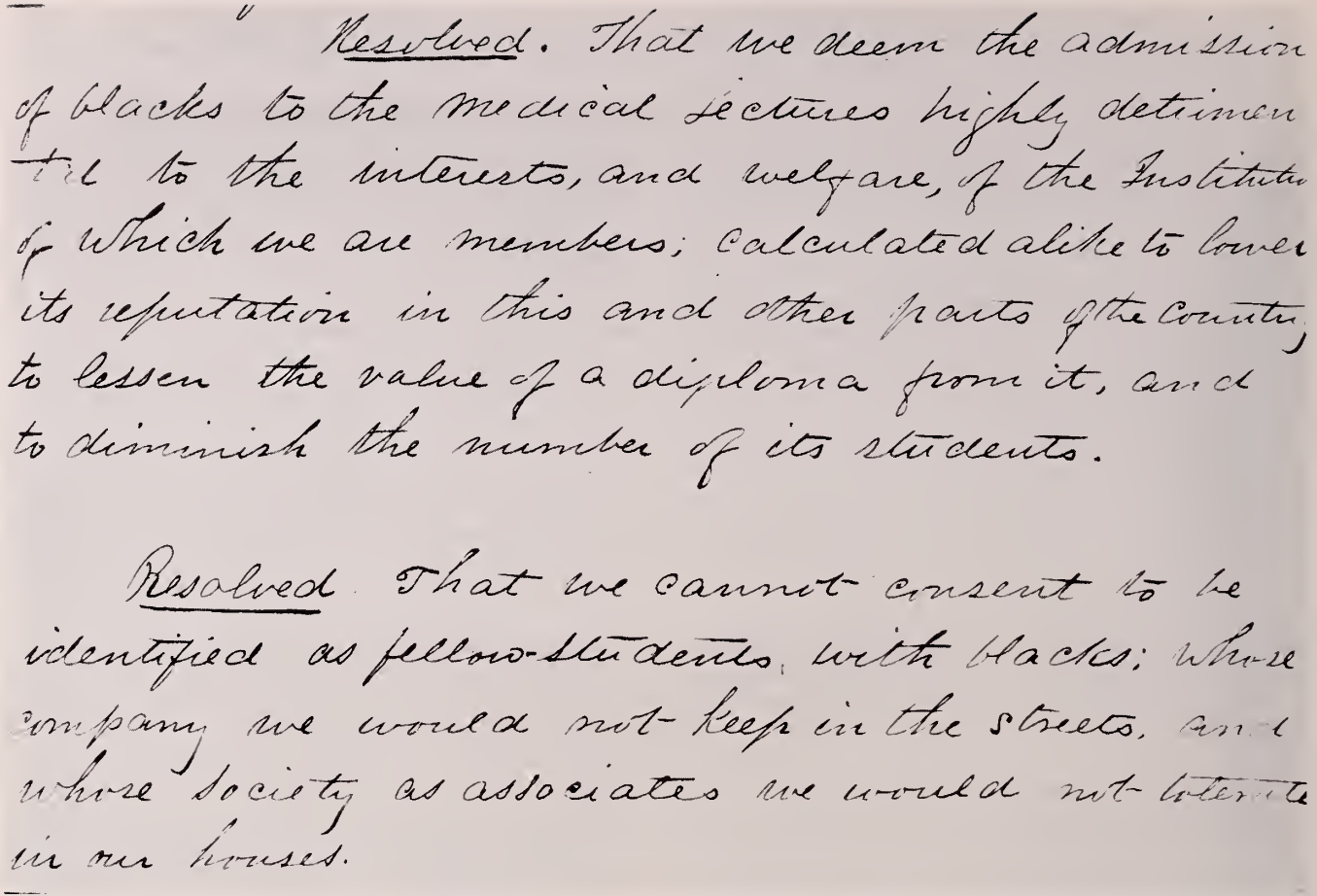
Several weeks after the acceptance of Laing and Snowden another black appeared in Dean Holmes's office to seek admission to the winter semester, then already underway. This was the formidable Martin Robison Delany, thirty-eight-years-old, jet black, of a squat, muscular build, and already well-known in abolitionist circles throughout the North. Delany's application was more of a challenge than those of Laing and Snowden. His intention was both to earn a medical degree and to practice in his native country. However, he possessed impressive credentials. There were strong letters of recommendation from his preceptors, Drs. Joseph Gazzam and F. Julius Le Moyne, eminent Pittsburgh physicians who also were abolitionists. In addition, there was a letter of endorsement signed by ten other members of the Pittsburgh medical fraternity and another signed by seven practitioners from neighboring Allegheny City. Lastly, three black ministers from Pittsburgh had written testimonials regarding Delany's solid moral character. Holmes was undoubtedly swayed by this support as well as by the force of Delany's personality. He may already have heard of Delany, and apparently did not anticipate any serious difficulty. Holmes admitted him the same day.

Before moving on to an account and analysis of the student reaction to the admission of these three blacks, and the consequent faculty response, a closer look at the career of Delany up until this time is in order. He was born in Charles Town (Charleston), Virginia (now West Virginia) in 1812 of a free mother and a slave father who obtained his freedom when Martin was ten. The family fled to Chambersburg, Pennsylvania in 1822 and Martin went on to Pittsburgh in 1831, at the age of nineteen. Over the next two decades Delany left a strong and favorable mark on this brawling, bustling river city. He was a leader in various black self-improvement societies, black politics, the Underground Railroad, and the abolitionist movement. His greatest influence and fame, however, came to him as the founder and editor of the excellent and pioneering black newspaper, *The Mystery*, still in print today as the *Christian Recorder*. Delany also found time to marry Kate A. Richards, the mulatto daughter of a wealthy black Pittsburgh landowner and merchant who was swindled out of his estate because white lawyers refused to take the case of a rich black against fellow whites. Martin and Kate were to have eleven children, seven of whom lived to adulthood.

In 1848, Delany left Pittsburgh to go to Rochester, New York where he joined with Frederick A. Douglass and William Nell of Boston in founding the *North Star*, the leading black newspaper of the ante-bellum period. After eighteen months Delany left this newspaper in the capable hands of Douglass and returned to Pittsburgh.

Throughout these intensely active years Delany also had a continuing interest in medicine. Early in his Pittsburgh days he had begun studying the medical arts with Dr. Andrew N. McDowell, but did not have the resources to complete his apprenticeship. He then earned a part of his livelihood as a cupper and bleeder for many of the doctors of the region. However, in 1849, buoyed by the fact that a few blacks were now being accepted by American medical schools (although most of them were supposed to be emigrating to Liberia), he renewed his apprenticeship, this time with Drs. Cazzam and Le Moyne.

After finishing his apprenticeship Delany began to apply to medical colleges. Since most of the doctors in and around Pittsburgh who had attended regular medical schools were from Jefferson and the University of Pennsylvania, he applied to these Philadelphia institutions, but was refused entrance. The School of Medicine at the University of Pennsylvania had a predominantly southern student population during this era. Of the 144 men who graduated there in 1838, a typical year, over half were from Dixie [see



Resolved. That we deem the admission of blacks to the medical lectures highly detrimental to the interests, and welfare, of the Institution of which we are members; calculated alike to lower its reputation in this and other parts of the country, to lessen the value of a diploma from it, and to diminish the number of its students.

Resolved That we cannot consent to be identified as fellow-students with blacks; whose company we would not keep in the streets, and whose society as associates we would not tolerate in our houses.

Richard H. Shryock, *Medicine In America: Historical Essays* (Baltimore, 1966), 56, f. n. 19]. Undaunted, Delany then applied to Geneva, where a woman, Elizabeth Blackwell, had just completed her studies, and to Albany Medical College. But again he was rejected. Following this, a Pittsburgh merchant by the name of John Cook suggested the Berkshire Medical College in Pittsfield, Massachusetts. Cook knew Dr. Henry Childs, the dean, and offered to write him a letter of introduction and recommendation. This time Delany applied in person. Berkshire had already accepted three blacks, but they all were destined for Liberia. When Delany told Dean Childs of his intention to practice in America he once more was denied admission. However, Childs did send him on to see his friend, Dean Holmes of the Harvard Medical School. With Holmes's approval, Delany's long quest seemed about to be fulfilled.

However, this dream, like so many others in his life, soon was to be shattered. On Tuesday morning, December 10, the students of Harvard Medical School, already in a state of agitation, assembled to consider the question of the three blacks in their midst and the rumor that a woman was soon to join them. At this morning session a committee was appointed to draft resolutions. This committee was headed by J. Randolph Lincoln as chairman and Edward Payson Abbe (A.B., Yale) as secretary. Both men were Bostonians. The meeting was then adjourned until the afternoon when a smaller number of students — about sixty out of a class of 116 (counting the three blacks) — reassembled. At this afternoon meeting two series of resolutions were passed and forwarded to the medical faculty. The first series expressed

In contrast to the resolutions reproduced above, consider this response from a different group of HMS students:

> **"The undersigned members of the Medical Class desire to express their dissent from the resolutions adopted by the class in regard to the colored students attending the Lectures, and their entire acquiescence in the course which the Medical Faculty have seen fit to adopt in relation to these individuals.**
>
> **"Their prejudices would perhaps lead them to wish that no occasion had occurred for the agitation of this question; but, as students of science, above all, as candidates for the profession of medicine, they would feel it a far greater evil, if, in the present state of public feeling, a medical college in Boston could refuse to this unfortunate class any privileges of education, which it is in the power of the profession to bestow . . ."**

opposition to the admission of a woman and were passed with little or no dissent. The second series protested the admission of the three blacks. These were much more controversial and were passed over strong objection. The arguments in these resolutions have a familiar ring: the students had not been informed that such a decision had been made, the presence of blacks would cheapen the Harvard medical degree, the quality of education would suffer, the presence of an inferior race was socially offensive.

The students who opposed the second series of resolutions were led by William Fifield of Weymouth, Richard Gundry of Simcoe, Canada West (Ontario), and Adams Wiley (A.B., Harvard) of Roxbury. They held another meet-

ing the following day and drew up two petitions to present to the medical faculty. The twenty-six signers of the first petition, acting, they averred, as "students of science" and "candidates for the profession of medicine," solidly endorsed the decision to admit blacks. Twenty-one of these men were from Massachusetts (eleven from Boston, two from Roxbury, two from Weymouth, and one each from Cambridge, Charlton, Essex, Lowell, Salem, and Springfield). Two others were from Connecticut and Vermont. The remaining three were from outside New England (two from Canada West and one from Farmington, Iowa). Six had graduated from Harvard College and one each from Brown and Dartmouth. The students from Iowa and Vermont already held M.D. degrees, probably from rural medical schools. Four of these signers (Fifield, Gundry, Lothrop, and Waldock) were to win Foster prizes at graduation.

The second petition took a more neutral stance. It opposed the second series of resolutions (which decried the admission of the blacks), but did not support the blacks. Twenty-two students signed this. Ten were from Massachusetts (five from Boston and one each from Dorchester, Framingham, Needham, Tisbury, and Salem). Curiously, eight were from Maine. The others were from Canada West, Mississippi, New Hampshire, and Rhode Island.

In addition to these petitions there were two others — opposed to the retention of the blacks — presented to the medical faculty. One, submitted in late December or early January, contained the signatures of fourteen or fifteen students who threatened to leave Harvard should the blacks remain beyond one term. One signatory, Mr. A. J. Webb, is not to be found in either the *Matriculating Book* or the *Catalogue of Students Attending Medical Lectures, 1850-1851.* Of the rest, six were from Massachusetts (three from Boston and one each from Beverly, Charlestown, and Fall River), two were from New Hampshire, two from Canada (New Brunswick and Nova Scotia), two from the South (Kentucky and Mississippi), and one each from Brazil and Connecticut. Two of these students were from Harvard and one each from Dartmouth, Williams, and Yale. The Mississippi student, Mr. William Dickinson (A.B., Dartmouth), had also signed the petition that opposed the second set of resolutions but did not support the blacks.

The other petition opposing the blacks is at best insignificant. It contains only eight signatures and five of those names are in neither the *Matriculating Book* nor the *Catalogue,* while two others were on the other petition in opposition to the retention of the blacks beyond one semester. The remaining signatory was John Randolph Lincoln, who had been chairman of the committee that drafted the two series of resolutions.

These petitions seem to indicate three things. First, there clearly was a strong body of active support within the medical class for Delany, Laing, and Snowden. This was especially noticeable among those who came from eastern Massachusetts, and it was from there that Harvard Medical School drew the bulk of its students until well into the twentieth century. Secondly, another large scholastic group, probably a clear majority, were almost certain to go along with whatever decision the faculty made regarding the blacks. Lastly, while those students strongly in opposition to the retention of the blacks undoubtedly were very vocal and active, they were a distinct minority and geographically scattered.

On Thursday, December 12, the entire medical faculty met to consider the student resolutions and petitions. At this time no decisions were made, but Holmes and Jacob Bigelow were appointed to take up the question of the continued presence of Delany, Laing, and Snowden. The following evening, the faculty, with the exception of Channing, reconvened at Holmes's residence on Montgomery Place. At this meeting they quickly disposed of the student concern over the possibility of a woman being accepted into their class, noting that the female applicant had, upon the advice of the faculty, withdrawn her request for admission; therefore, no further action was necessary. A resolution, drafted by Holmes and addressing the question of the black students, was then presented to the faculty by Jacob Bigelow. It stated that since these students were already in possession of their tickets of admission to the various courses, they were entitled to complete the semester. This resolution was approved, although the votes were not recorded in the "Minutes." Possibly the vote was unanimous, but Henry J. Bigelow may well have dissented. Holmes passed these decisions on to the student body.

The female applicant who had caused such consternation among the Harvard medical students was Harriot Kezia Hunt, a forty-five-year-old Boston practitioner, feminist, and reformer. She and her sister, Sarah, had been trained by an English couple named Mott who were effective but irregular physicians — basically herb doctors. Harriot had then developed a large practice, almost exclusively among women and children. Her regimen stressed good nursing, diet, bathing, exercise, rest, and sound hygienic practices — all of which should have pleased Jacob Bigelow, Boston's premier crusader against heroic therapy. Hunt also showed a strong interest in the roles of the mind and personality in illness. In 1843 she had organized a Ladies Physiological Society in Charlestown, Massachusetts.

In December of 1847 this matronly and surprisingly successful female medical pioneer, acutely aware of her limited knowledge of the scientific foundations of medicine and encouraged by her friends, had applied for admission to the lectures at Harvard Medical School. Earlier, in July, at a meeting of the medical faculty Dr. Channing had raised the question of whether a woman might be admitted to the medical lectures and be awarded a medical degree. This query may have been in response to talk that Harriot Hunt was contemplating applying to the school, or to the actual application made by Elizabeth Blackwell sometime during the spring or summer of 1847. At any rate, the medical faculty quickly referred Channing's question to President Everett and the Harvard Corporation. At a special meeting on August 14 they concluded that it would be "inadvisable" for the medical school to accept women. However, there is no indication that Hunt knew of this decision when she applied in December to attend the medical lectures. Her application also was referred by Holmes, but this time to the president and fellows of the university. They met on December 27 and declared that it was "inexpedient" to reconsider the August 14 vote of the corporation.

Over the next three years Hunt continued her successful practice, gave a free course of public lectures on physiology and hygiene, and became active in the nascent

national women's rights movement. Then, encouraged by the rising tide of female activism both inside and outside of medicine, she reapplied in November, 1850, to attend the medical lectures at Harvard. On November 23, the medical faculty voted five to two (with Bigelow, Sr. and Jackson dissenting) to admit her to the medical lectures, but not for a degree, if this was not "inconsistent" with the laws of the university. Holmes sent the corporation Hunt's request and the medical faculty's response, together with a letter in support of her application. On this occasion, the corporation expressed no objection, "if the Medical Faculty deem it expedient." However, the ensuing uproar caused Hunt's supporters to beat a hasty retreat. It would be 1866 before another woman would apply to Harvard Medical School and not until 1945 that females would be accepted. Thus did Harvard move from the vanguard to the rearguard in the medical education of women.

As for the indomitable Harriot Kezia Hunt, she received an honorary M.D. degree from the Female Medical College of Philadelphia in 1853 and continued to enjoy a large medical practice and considerable medical influence almost until her death in 1875. She was buried in the family plot in Mount Auburn Cemetery where her grave was marked by a statue of the goddess Hygeia.

If Hunt never made it to the Harvard Medical School, the stay of Delany, Laing, and Snowden was all too brief. At a meeting of the medical faculty on December 26, it was deemed "inexpedient, after the present course, to admit colored students to attendance on the medical lectures." Supporting this decision were the Bigelows, Holmes, and Jackson. Opposed were Channing and Ware. Horsford was excused from voting. Channing tried to have the question of admitting blacks to the medical lectures referred to the president and fellows of the university for a final decision, but this too was voted down. Holmes was directed to write a letter to the Colonization Society informing them that "this experiment" had satisfied the medical faculty "that the intermixing of the white and black races in their lecture rooms, is distasteful to a large portion of the class and injurious to the interests of the school." Curiously, there was no great outcry either among Boston's blacks or the abolitionists or other reformers over this regrettable decision. Apparently, there were at this time just too many battles being fought both internally and externally by these groups. It was not until Edwin Clarence Joseph Turpin Howard graduated in 1869 that the Harvard Medical School produced its first black doctor.

After their dismissal from Harvard Medical School, Laing and Snowden continued their struggle to complete their medical educations. Laing first went to Paris where he studied under the master surgeon Velpeau and then returned to receive his M.D. from Dartmouth in 1854. Snowden renewed his studies with Dr. Clarke. In November, 1853, he reapplied for admission to the Harvard Medical School, indicating that he still intended to go to Liberia. His application was supported by a petition signed by seventy-five members of a medical class of 118, including Samuel Abbott Green, later president of the Massachusetts Historical Society and author of a classic history of Massachusetts medicine; Edward L. Holmes, later president (1890-1898) of Rush Medical College; Israel Tisdale Talbot, the first dean (1873-1899) of the Boston University School of Medicine, and Conrad Wesselhoeft, later a distinguished pathologist at Boston University School of Medicine. This petition supporting Laing shows that in 1850-1851 there was not only a strong nucleus of support for the blacks among the students then in attendance, but also among those who were soon to matriculate. Nevertheless, the medical faculty voted down Laing's reapplication, even though only eight students were in opposition.

Harriot Kezia Hunt

It is possible that both Laing and Snowden emigrated to Libera in 1854. However, if this is true, at least Laing apparently returned to the United States, and died in Charleston in 1869.

From the time he left Harvard Medical School in March 1851 until just before the Civil War, Delany practiced medicine both in Pittsburgh, where he received a citation from the board of health and the city council for his work during the cholera epidemic of 1854, and in Chatham, Canada West (the fugitive slave capital of Canada), where he moved in 1856. However, he also worked ceaselessly for the destruction of slavery, the rights of free blacks, and voluntary black emigration (he even made an exploratory trip to the Niger Valley in 1859-1860). Somehow, he also found time to write one of the earliest black novels, called *Blake; or, the Huts of America,* which depicted a fictional general slave revolt in the South.

During much of the Civil War, Delany served as a highly successful recruiter of blacks for the Union Army. Indeed, it is worth noting here that nearly ten percent of the Northern troops were black [see James McPherson, *The Negro's Civil War* (New York, 1965), 237]. On February 18, 1865, he was commissioned as a major in the infantry, the

first black field officer in the history of the United States Army. He remained in the army until 1868, serving chiefly with the freedmen's bureau in Hilton Head, South Carolina. Following his discharge he remained highly active in the politics of the Palmetto State until the collapse of Reconstruction. He then rejoined his family in Xenia, Ohio, near the campus of Wilberforce College, where, in an increasingly hostile society, he continued the struggle for black rights and black pride until his death in 1885.

From the vantage point of 1980 it can be maintained with considerable conviction that the Harvard Medical Faculty, and particularly Dean Holmes, in 1850-1851 made a wrong turn which did much to deprive the Harvard Medical School of the kind of leadership in the social dimension of the medical profession that it has enjoyed in the clinical and scientific areas. Delany, Laing, and Snowden could have been allowed to complete their medical education. Holmes was influential and adroit enough to have carried the medical faculty with him had he decided in favor of the blacks. There also was enough support among the students to have kept the unrest and economic damage within reasonable bounds. The student petition of 1853 shows that there also was strong support, among those who would enroll in the school in the near future, for at least some black presence. What's more, Boston in the 1850s was moving toward greater support for black rights, as demonstrated by the admission of John V. de Grassa (Bowdoin M.D., 1848) to the Boston Medical Society in 1854, and the desegregation of the public schools in 1857. Also, if Harvard Medical had retained the black students in 1850-1851, it probably would not have taken another century for women to be admitted.

However, from the perspective of 1850, things take on a different aspect. The medical faculty, and especially Holmes, were deeply affected by the Parkman murder case and the fact that the Fugitive Slave Act was tearing apart their beloved Brahmin class. And they were forced, all within a few months, to adjust to the idea of accepting a woman, two young blacks destined for Liberia, and a controversial mature black of strong personality who intended to take a degree and practice in America. Little wonder that a moderate amount of student discontent should have unnerved them, especially since the Bigelows already were aggressive social conservatives. Lastly, while Holmes was a man of amiable good will, he also was a dean, and deans are seldom given to prophesying or crusading. Thus, if the Harvard Medical faculty made a mistake at this time, it was a very human and a very understandable one. □

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letters

The debate continues

As part of the general discussion of the Harvard Community Health Plan in the June HMAB *we published two personal letters written by Ira Marks '59. Inasmuch as we failed to inform Dr. Marks in advance that his letters were to be included in the issue, and because the letters were more than a year old and did not take into account additional facts recently made public, we have given Dr. Marks the opportunity to make the rather extended, further comments that follow. — The editors.*

In order to gain a perspective on the controversies currently surrounding the HCHP, it is of prime importance to ascertain the total history of the founding of the HCHP. By this I mean not only whose idea it was, and how it was funded, but also with what explanations and justifications the Plan was first presented to the faculty of Harvard Medical School. After all, without the formal acceptance of the faculty of the Medical School, the *Harvard* Community Health Plan would not have been either so named or initiated.

Dean Ebert tells us that "HCHP was conceived and inaugurated by Harvard." He also informs us that he "personally raised the money from foundations to start HCHP." The HCHP needed up-front funding and Harvard did for it what, in certain respects, the federal government is doing for newer HMOs. However, there is one major difference: Harvard attached no controlling strings to the funds it obtained for the plan.

Throughout the discussion in the *Bulletin*, one point is consistently made: HCHP is *now* functionally independent of HMS. But it is precisely because HCHP is, presently, functionally independent of HMS that it is relevant to know whether this autonomy and its potential consequences were fully presented to and understood by the faculty when the plan was financially dependent on the Medical School. What were the expectations and goals of the plan and how were they explained to the faculty in order to win their support? To be specific, did the faculty understand how independent of Harvard the CHP would be?

Here is an area of history which at least to this observer seems shrouded in mystery. Dr. Perry Culver states, "When this plan was originally debated in the faculty there was quite a bit of effort to try and sell it." With reference to a statement by a critic, repeated by Dr. Gordon Donaldson, "The alumni were told first, that the Medical School would have a major voice in controlling the policies and function of the organization and second, that the service area would be only those areas of Boston that were physically contiguous to the Medical School or particularly undoctored." Dr. Culver says "statements like that were made to win the faculty's approval."

There was stress put on HCHP's intention to serve the indigent population of the area. For example, the original plans looked forward to an enrollment of 30,000 members — of whom 6,000 would either be funded by medicaid or through public health grants. Although the goals with regard to indigents were never reached, this ambition to serve the poor was also part of the "selling" to the faculty. Serving twenty percent indigents sounds more like what a Harvard plan would be doing than the twelve percent of 1972 or the four percent of 1979. In the last six years, while membership has tripled, the percent of indigents served by the HCHP has dropped to one third what it was and one fifth what was originally projected. One can only wonder what this figure will be after Wellesley and the proposed northern and southern extensions of the Plan are completely enrolled.

It seems appropriate to ask: Who made the statements referred to by Dr. Culver? Does the present administration of HMS stand by the positions that were used to "sell the plan" to the faculty? Does it not feel responsible for commitments verbalized in the past? If the faculty is to retain its credibility and self-respect, and if the plan is to continue calling itself the "Harvard" CHP, one would think that this growing force in the health community of greater Boston would have to be responsible for a significant portion of the original goals by which it had won the faculty's approval.

Beyond this, there is the whole matter of the use of HCHP as an ambulatory educational facility at Harvard Medical School — no doubt, an issue that also entered into the original discussions. Dr. Ebert stresses that "HCHP has been a central force in the development of a primary care residency program at Harvard." Dr. Moore, the medical director of HCHP, states, "The primary care program has been a source of great pride at the medical school — rightfully so — and it is a program in which we have been an absolutely major participant." Moreover, Dr. Spellman informs us that "during the fiscal year October 1978 to September 1979 there were opportunities for a total of sixty-nine to eighty-seven medical preceptorships and clerkships at HCHP."

But what do we find when we look beneath these pronouncements to the realities? To our surprise and, perhaps, embarrassment, we discover that, in the first place, HCHP is (I quote Dr. Moore) "the site for training between twelve and fifteen residents," and second, (I repeat information obtained from the Dean's office) not a solitary HMS student took advantage of the sixty-nine to eighty-seven "opportunities" for preceptorships and clerkships available last year.

In fact, then, the HCHP, this "central force" for the teaching of primary care at Harvard, is a whale that has labored and brought forth a herring. HCHP is training a mere twelve to fifteen of the 1276 residents at Harvard's affiliated hospitals, and HCHP preceptorships have not trained a single HMS student.

The editors welcome letters from readers, particularly in regard to articles published recently in the Harvard Medical Alumni Bulletin. *Letters should be brief, double spaced, submitted in duplicate, and marked "for publication." Not all letters can be used; those accepted will become the property of the* HMAB *and may be edited, although we are unable to provide pre-publication proofs.*

But these nitty-gritty statistics should come as no surprise to anyone familiar with HMS's real past record with respect to primary practice. Good teaching of primary care requires at least three ingredients: first, well-trained, enthusiastic practitioners; second, an ambulatory setting with patients who have primary complaints; third, a medical school atmosphere that encourages and appreciates primary care. It is this third ingredient alone which historically has been, and still appears to be, missing from Harvard. And it may be this same bottom-line indifference to ambulatory care on the part of HMS that has allowed HCHP to do whatever it pleases in the name of Harvard.

Dean Ebert, for example, emphasizes that his interest (in 1965-66) in establishing the HCHP came when "but a few of us were worried about such things as primary care." I assume that Dr. Ebert here refers to "us" as those in academic medicine at HMS. Most of "us" in primary practice personally know of dozens if not hundreds of fellow physicians who were then and still are worried about primary care. It seems obvious that for decades there have been many well qualified primary care physicians whose offices (that is, ambulatory care facilities) were minutes away from Longwood Avenue. But these facilities and skills were rarely utilized by HMS. Strangely, other medical schools, somewhere beyond Route 128, had learned to tap this same type of talent pool. At Harvard, however, only a massive, multi-million-dollar, formally-structured CHP would do as a setting for the teaching of office care.

In his letter to me, Dean Tosteson denies that Harvard philosophically denigrates primary care. Yet Dr. Doris Bennett, presently a pediatrician at HCHP, stated in the Alumni Council debate, "We have wanted medical students. Four or five years ago a professor of pediatrics came over to see us. She looked around, saw what we did, and said she could teach medical students in twenty minutes everything we had to teach."

One can only wonder what teaching use, if any, other professors at Harvard envision for HCHP. Millions of ambulatory patients are seeing thousands of primary care physicians for hundreds of concerns day after day. Yet this Harvard professor feels she can teach all of the knowledge, techniques, and relationships necessary to minister to these problems in twenty minutes! Dr. Tosteson is right: this is not philosophical denigration of primary care. It is rudeness; it is hubris; it is narrowness; it is egotism; worst of all, it is ignorance.

Five years ago HCHP was willing to accept students. Moreover, Dr. Spellman informs us that over fifty percent of the HCHP physicians hold faculty appointments and that seventy-two percent teach HMS students through positions at other facilities. What then has held up Harvard's involvement in primary care teaching at HCHP?

One can only assume that either the quality of teaching is not felt to be adequate or that there are such general pressures against primary care teaching at HMS that even what was hoped would be the flagship of primary practice education, the Harvard CHP, is suspect as a source of medical knowledge. The fact is that ambulatory education at the Harvard CHP remains minimal. To make believe it is otherwise, no matter what one's own personal wish may be, is self-deluding.

Evidently, for the Medical School the benefits from the use of the Harvard name in the Community Health Plan have been minimal. On the other hand, the benefits to the Community Health Plan have been enormous: first, its very existence; second, the stature the name Harvard adds (for example, in recruiting personnel); third, the attraction of members (patients) to a medical plan apparently sponsored and supervised by Harvard Medical School. It should come as no surprise that the HCHP has not changed its name as recommended by the Harvard Medical Center.

But even this suggested change in the title (to the Community Health Plan of the Harvard Medical Center), does not come to terms with the problem raised by the meaning that the Harvard name has for the most important group involved: the membership of, and the public solicited by, the Harvard CHP. All of the *Bulletin*'s contributors agree that the public believes it is receiving "Harvard" supervised medical care. But clearly this is not the case. Does Harvard Medical School acquiesce in this deception?

In her book, *Lying, — Moral Choice in Public and Private Life,* Sissela Bok comments:

> *"All our choices depend on our estimates of what is the case; these estimates must in turn rely on information from others."*

She goes on to state:

> *"Deception . . . can affect the objectives seen, the alternatives believed possible, the estimates made of risks and benefits. Such a manipulation of the dimension of certainty is one of the main ways to gain power over the choices of those deceived . . . deception can initiate actions a person would otherwise never have chosen."*

HCHP is deceiving the public and Harvard has countenanced this deception.

I take no joy in coming to this conclusion. When HCHP was first conceived, I had hoped it would fulfill all of its professed ideals — that it would show organized medicine that prepayment plans can work, that it would serve the poor and the neighborhoods contiguous to the Medical School area, and finally that it would bring ambulatory care into the Harvard community with the stature it deserves. I recognize now that this was naive on my part, perhaps even a bit quixotic. HCHP is going its own way for its own reasons — reasons which appear not to be too different from those of any economically oriented private physician or insurance company. And Harvard papers over the obvious and immense flaws in the school's relationship with HCHP rather than admit its inconsistencies.

Dean Ebert, proud father of the Plan, is also the chairman of the board of the HCHP corporation. Can he speak at the same time for the interests of the Medical School regarding areas of controversy between the two parties? And if he cannot, who can? Dean Tosteson? Dean Spellman? Does the Harvard faculty have nothing more to say on the issue?

As the Harvard CHP proudly enters the suburbs, does the *faculty* of Harvard Medical School still feel the use of "Harvard" in the Plan name is appropriate? Has HCHP fulfilled the goals which led the faculty to sanction its creation? If Harvard neither sets the standards of medical care nor chooses

the physicians of this independent CHP, is it ethical to allow the use of its name in a plan the public believes is under Harvard's auspices? Has Harvard made significant use of HCHP facilities to develop the teaching of primary care? Or any other facilities? Does Harvard truly wish to orient any of its students toward the concerns of primary care? Indeed, does Harvard *care* about *primary* care?

The answers to these questions require not misleading pronouncements, not stacks of self-serving statistics, not creative corporate constructions, and not accounts of agile agreements. They require plain speaking, straightforward statements of policy — policy that carries through in fact and funding and does not just repeat itself and congratulate itself over and over again on paper.

Ira Marks '59

As chairman and medical director of Bay State Health Care Foundation, Inc., I read your June 1980 *Alumni Bulletin* with considerable chagrin.

It appears that HCHP has done more than preempt the Harvard name. It has also managed, through Dr. Moore, to exploit the pages of the *Alumni Bulletin* to circulate falsehoods regarding its competition.

I refer in particular to Dr. Moore's statement on page 20 that "Bay State has its primary affiliation agreement with University Hospital." In point of fact, Bay State, as an open-panel HMO, has reimbursement agreements with some thirty-five hospitals, of which University Hospital is one — a fact of which Dr. Moore surely should be aware.

Incidentally, I note that Bill Christensen observed in the same issue that a "Philadelphia lawyer couldn't take [the Harvard name] from" HCHP. Our Boston lawyers (who are Harvard Law School graduates) advise me that if the use of the Harvard name by HCHP has the effect of misleading the public as to the nature of HCHP's relationship with HMS, HCHP may well be committing an unfair trade practice prohibited by Massachusetts and Federal law.

Robert J. Brennan, M.D.

I want to express my disappointment in the editorial activities of the *Alumni Bulletin* as evidenced by my section in the *Bulletin*'s report in June on Harvard Community Health Plan. This section was put together from taped materials taken from a question and answer meeting with the Alumni Council. The translation of these spontaneous comments in response to questions into the statement which was printed has led to several errors of both fact and tone. I believe that this problem is inevitable, using the materials which you had as source information, but I was most distressed to find a printed article which had not been sent to me for review by the staff of the *Bulletin*. I believe the accuracy of my section, and perhaps of some of the others, could have been enhanced had I been given the opportunity to review and to correct the article before you sent it to press.

Gordon T. Moore '63
Medical Director
Harvard Community Health Plan

Dr. Moore's description of our method is accurate; we took what we considered the substance of his remarks from the transcript, just as we reduced the presentations of Drs. Spellman, Kaufman, and Sidd to readable, publishable dimensions. We hoped to preserve the forthright, unequivocal tone of the discussions in those Alumni Council sessions, and therefore did not submit our edited versions to any of the four speakers for review. We invite the correction of "errors of both fact and tone" which may have resulted.— The editors.

I read with great amusement the contentious debate about the Harvard Community Health Plan. Although I do not have much sympathy for the plight of private practitioners competing with HCHP, I do want to make a couple of small points.

First, in response to Dr. Ebert's claim that the "Harvard Community Health Plan was conceived in 1965-1966 before . . . any federal funds were available for planning HMOs . . . [and] when biomedical research funding was going up and not down," my reaction is one of incredulity. Ironically, Alana Cohen and I considered this problem in an article published in the *Alumni Bulletin* in September/October 1972. Figure 1 of that article showed quite clearly that government and philanthropic receipts of Harvard Medical School had plateaued in 1965-1966 and subsequently fell. We also showed that outside support for HCHP increased rapidly, beginning in 1967-1968. We argued at the time that the development of a large HMO was a technique to counter the forthcoming fiscal crisis of the medical school and associated teaching institutions, a crisis anyone could predict by observing the decline in the rate of increase of federal funding that already was apparent by 1965-1966. The subsequent bonanza that HCHP created, including expanded teaching and research empires associated with the medical school, amply fulfilled the expectations of the founders. When Dr. Ebert asserts it is a "myth that Harvard became interested in pre-paid medical care after there was a decline in federal funding for research," he either lacks candor or is forgetful.

Secondly, I want to add a small perspective regarding cost savings of HMOs. One of the reasons that HMOs like Kaiser save money is that they provide impersonal, bureaucratized, and inefficient services that many subscribers dislike. Kaiser subscribers frequently use outside services. The costs of this do not enter into the calculations that show apparent savings. At this particular community clinic, about ten percent of our patients have Kaiser coverage through their jobs but come to our clinic because of dissatisfaction. Similar outside utilization has been found now in studies sponsored by unions. But most published studies of cost savings ignore this important consideration.

There are many other reasons to be skeptical about the reported benefits of HMOs. In particular, HMOs make no broad attempt to reorganize the health system as a whole. These larger issues should inform the debate about HMOs as a policy alternative, rather than the less lucrative returns private practitioners anticipate as a result of HMO competition. Frankly, I think we should seek to eliminate the medical marketplace altogether rather than simply thwarting HCHP and Kaiser. This would involve a struggle to create a national health service and major changes in the capitalist structure of our health-care system. But that is another story.

Howard Waitzkin '72
Internist and Coordinator of
Adult Medical Services
Clinica de la Raza
Oakland, California

It seems to me that nobody has brought up the most important advantage which the Harvard Community Health Plan derives from its relationship with the school — namely, its enhanced ability to attract the physicians it wants for its staff. While I cannot judge how much effect the Harvard name may have had on the plan's original ability to recruit membership, I am certain that no plan can grow continuously unless it is providing services which a large portion of its membership finds satisfactory. The word-of-mouth effect in the marketplace of consumer satisfaction or dissatisfaction spreads rapidly and is of far greater weight in affecting enrollment than any name. Ability to recruit physicians is another matter. High quality care that meets the expectations of the patient comes from, and only from, well motivated, competent, caring physicians. Since it is unreasonable to expect physicians who have made the investment of the time and money to build up their own practices to be interested in abandoning them, the large number of new and established HMOs are competing for physicians among the relatively small pool of graduating residents, only some of whom are interested in this method of practice.

I have spent almost my whole professional career working in a prepaid practice and for the past eleven years I have been the medical director of that group, the East Nassau Medical Group, which is one of the largest and most successful of the groups associated with the Health Insurance Plan of Greater New York. During that time there have been periods when we have had difficulty in recruiting the physicians we wanted; we have refused to hire physicians we felt did not meet our standards and had to let go physicians we felt unsatisfactory even though we experienced significant understaffing. As we have grown and expanded, the name of our group (a geographical designation) no longer fits the region we service. If, as a result of this controversy, Dr. Gordon Moore and his associates decide to change their name, perhaps we will be able to solve our problems by renaming our group, The Harvard Community Health Plan!

Jesse H. Jampol '49
East Nassau Medical Group

The enjoyable reading about the Harvard Community Health Plan was interesting, but quite tangential to the real issue at hand. Those of us in practice in central New Jersey have a quite similar situation. The Rutgers Community Health Plan is a 40,000 member health maintenance organization. While it is inconceivable for a Harvard graduate to imagine that anyone could equate Rutgers with Harvard, in fact it is very much the case. Furthermore, the Rutgers Community Health Plan has nothing whatever to do with Rutgers University.

The real issue, however, is simply the growing oversupply of physicians. Most physicians choose to look at certain collectivist arrangements as the cause of a problem of which, in fact, they are mere epiphenomena. Not surprisingly, the oversupply of physicians has hit Boston first, is starting to be felt now in various portions of the northeast corridor, and will become a national issue very, very soon. Medical schools have too much at stake to identify this issue, for it would mean a sharp cutback in training programs, fellowships, and generally a bear market for medical education.

Matthew Menken '62
Clinical Associate Professor
Rutgers Medical School

In "The Alumni Council Debate: June, 3, 1980" (*HMAB*, June 1980), Jane Schaller worries that, "There's also the feeling that this organization is going to go on in uncontrolled growth and spread out and engulf the entire country, probably ending up in Seattle." *Au contraire*, Jane. It started here. Fifty years ago, in and around Seattle, there were dozens of small HMO-type operations. Individuals or small groups of doctors signed up logging operations, small businesses, manufacturers, and other groups to provide all of their medical care at so much per head. Practically everybody had a small group of captive patients for whom he was physician. It was sort of a medical boarding house arrangement where the patient got the standard fare as dished out by the doctor. And the less money the doctor spent the more he got to keep.

Doctors began to think that this was not a very good arrangement. The patients had no free choice of physician and physicians were not apt to refer patients elsewhere. So the medical care left something to be desired. In addition, new physicians coming into the community found there were very few patients uncommitted to some HMO-type operation. It was tough to get a toehold in practice.

As a result, it was decided to ask all physicians to pool their contracts and form the King County Medical Service Corporation, later King County Blue Shield. Most of the doctors did this and patients had the advantages of prepaid medical care, freedom to choose any physician in the community and to be referred appropriately at no added cost. New physicians found that they could start practice and compete on the basis of excellence of service rather than on who had what contract.

King County Blue Shield now is by far the largest group in our community. Group Health Cooperative was begun by physicians who did not yield up their contracts but who continued the standard closed panel system. It is the HMO in this area and is held up as a classic example of this form of prepaid medical care. There is no other local HMO so it has no competition with another unit of its same composition. It competes against Blue Shield and private insurance carriers, both of which have succeeded without federal subsidy.

And so, Jane, the HMO movement in this country was born right here in your home town. Don't look for it to surface anew out here. It's been here all the time.

Eric R. Sanderson '37

Your issue of June 1980 outlines a fascinating debate between the Harvard Community Health Plan and alumni in the area who are facing competition unfairly loaded against them by the Harvard name. I have a brief comment from the international perspective — perhaps of interest because the eventual decision will have an impact beyond the local environs, just as much of what Harvard does becomes a worldwide model.

In India's "sunny clime," where I spend much of my time, we have for many years been trying to get each medical college to assume responsibility for three community development blocks — or total populations of about 300,000 population. Just as they run

teaching hospitals each medical college would take responsibility for total health care. Each field practice area would provide a base for the teaching that is necessary to prepare Indian doctors for what they will really be doing when they graduate, running the one primary health center serving a block of 100,000 people. This means obviously that they will rely mostly on auxiliary nurse midwives and community health workers scattered in subcenters serving 5,000 population for initial patient screening. With many others we have been trying to reorient medical education so that "community-side" teaching becomes as accepted as "bedside" teaching.

Beyond the teaching function there is the challenge of using these three blocks for research — not sophisticated biomedical research but the kind India needs to find answers to the intractable problems of reaching the poor and helping people to solve their own health problems. WHO and UNICEF are trying to develop a worldwide network of centers for health services research. The India network under the Indian Council of Medical Research will be the prototype national network. Our department has been working for many years to promote the notion of field practice areas in Nepal, Bangladesh, Sri Lanka, Thailand, Indonesia, Philippines, Korea, Peru, Tunisia, Egypt, Kuwait, Saudi Arabia, Ethiopia, Kenya, Nigeria, and other countries.

Our efforts to promote community-side teaching and research have been greatly facilitated by being able to refer to the Harvard Community Health Plan in order to get acceptance of the idea that this does not represent second class medicine. I am disappointed to learn that HCHP does not have a formal academic linkage. To indicate its commitment to primary care I would strongly urge that Harvard Medical School should develop precisely the same formal and contractual arrangements with HCHP as they have with the MGH, Beth Israel, and the Brigham.

Carl E. Taylor '41
Professor and Chairman
Department of
International Health
School of Hygiene
and Public Health
The Johns Hopkins University

. . . but no thanks

Thank you for publishing my family news in the June 1980 "Alumni Notes." All of the information about my move and the arrival of my daughter was correct, except for one thing — I graduated in the Class of 1973, not 1971. I've already had some comments from colleagues who wondered if I'd skipped a couple of classes! I appreciated the promotion but I still prefer my own class (it was a very good year).

Melvin D. Young '73

alumni notes

1920

John J. Sampson is happy to relate that he is still working at practice, teaching, and clinical research: "two more publications in the present year."

1922

"Still in practice and seeing several patients for psychotherapy," writes **George E. Daniels.** "March 1, 1980, my wife Helen and I had our fiftieth wedding anniversary. On June 29th, our son John and his wife Catherine gave a very nice anniversary party for us with twenty-five guests coming from various sectors of family and friends. We keep in fair health."

Joseph Goldman feels fortunate that he "can retire in good general health and able to enjoy continued deep interest in medicine and in my hobbies of travel, garden, photography, and family life."

"Ruth and I are in excellent health and enjoying every day," reports **Howard B. Goodrich.** Since his retirement in 1978 he has had time to catch up on the sizeable clan engendered by his five children: Jane (Mt. Holyoke, 1943), married to an outstanding internist, two children, one grandchild; Sydney (Washington U., St. Louis, 1947), assistant dean at Stanford, four married children (two Stanford graduates), four grandchildren; Howard, Jr. (Wesleyan, 1950), regional minister for the central northwest of the Disciples of Christ, three children, two married; Averill (Denison University and Rollins, 1953), three children, her twin girls at Vanderbilt; Ruth "Honey" (Rollins, 1962), husband a Navy Commander, two children in school. The grand total? Five children, fourteen grandchildren, and five great-grandchildren.

1923

At "the ripe old age of eighty-two years," **Randolph L. Anderson** has shortened his hours "a little — but I am still working and enjoy it very much."

1924

Standing pat in his eighty-seventh year, **Fred W. Stewart** has "nothing to say. There are too many blatting Ayatollahs anyway."

1926

Walter B. Seelye is "enjoying a peaceful retirement, living in a condominium right on the shores of Lake Washington. Mrs. Seelye (Elinor) loves her work with the Audubon Society, having founded a new chapter this past year. Son Richard lives in Bellevue (next town), works for Seattle's METRO as an engineer. Son Bill is director of development at Providence Hospital in Anchorage, Alaska — that state's largest medical center."

1928

Eliot Snow has made a contribution to the Alumni Fund in memory of his youngest brother, **Willard '39,** who died of acute lymphatic leukemia in 1957. "At that time he was associate professor of medicine at Stanford Medical School, in charge of their arthritis program — a great loss to them and to his family." Dr. Snow continues to be in good health three years after a triple coronary bypass. "Each day I say a brief prayer of thankfulness for the progress of modern medicine — a progress that HMS has led the way in for so many years."

1929

The Society of Neurological Surgeons (the "senior" society, founded by Harvey Cushing in 1920) granted its distinguished service award to **Joseph P. Evans,** professor of neurological surgery, emeritus, University of Chicago, and currently director of the international department, American College of Surgeons.

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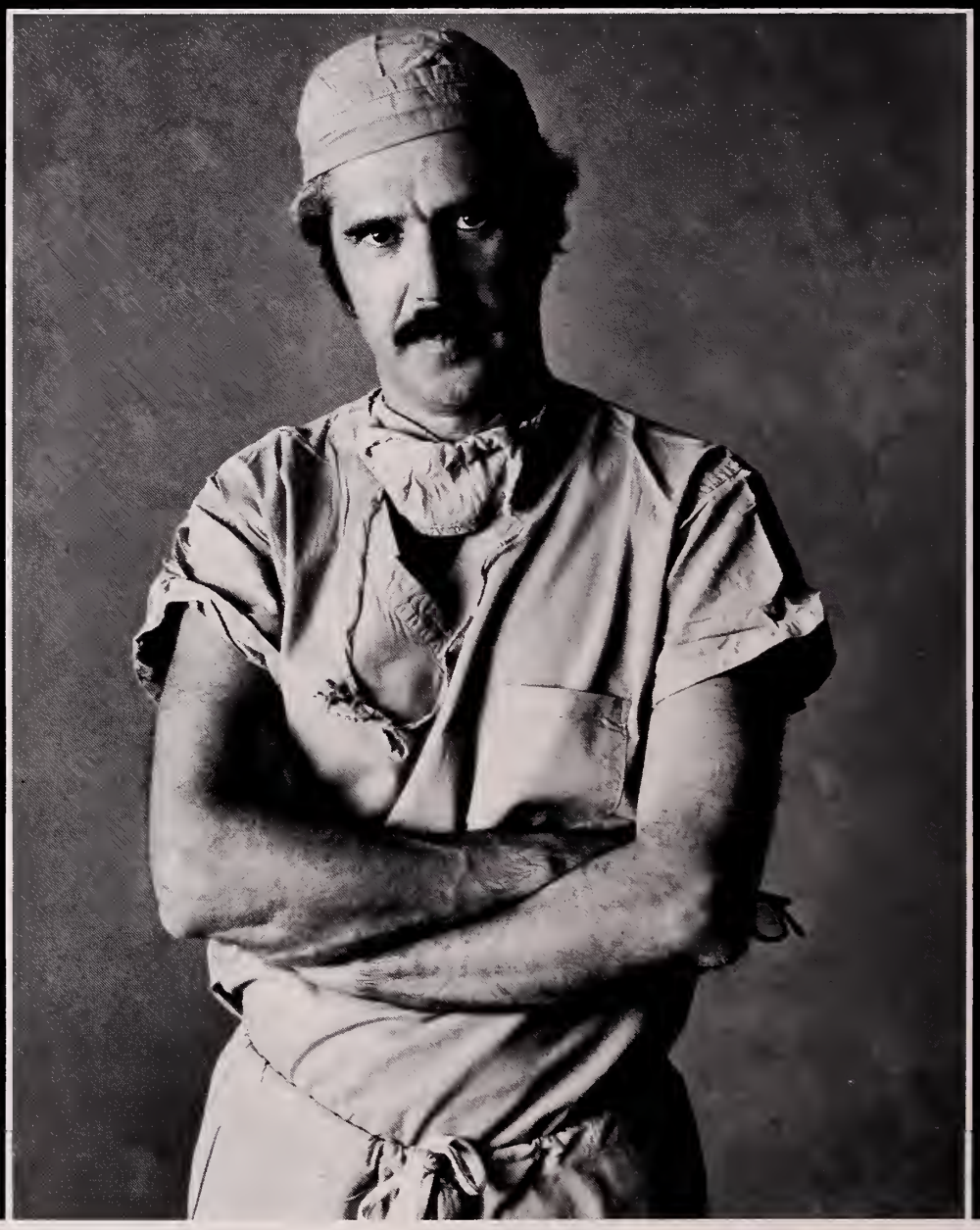

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